

Medical Treatment Guidelines

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Introduction

The Medical Treatment Guidelines review criteria contained herein were developed by the Office of the Medical Director in collaboration with the Washington State Medical Association Industrial Insurance Advisory Committee. These guidelines/review criteria are implemented in the prospective utilization review and claim management process. The guidelines/review criteria are published by the Department of Labor and Industries and the department is solely responsible for coverage decisions that may result from use of these guidelines/review criteria.

Note: *For more copies of the Medical Treatment Guidelines please write to: L&I Warehouse, Department of Labor and Industries, P.O. Box 44843, Olympia, Washington 98504-4843.¹*

GUIDELINE PROCESS

Medical Practice Guidelines in Washington Workers' Compensation

Background

The Washington State Department of Labor and Industries (L&I) Office of the Medical Director (OMD), in collaboration with the Washington State Medical Association (WSMA) Industrial Insurance Advisory Committee, has developed a process for establishing medical treatment guidelines. Under authority of WAC 296-20-01001, the WSMA committee advises and assists L&I on issues broadly related to the quality of medical care received by injured workers. From September 1988 to 2004, the WSMA medical guideline subcommittee met on a monthly basis to address medical practice issues.

The need to establish practice guidelines was recognized by the members of the Washington State Medical Association committee in 1988, when the inpatient utilization review (UR) program was established. This program provides preadmission medical necessity review for inpatient admissions, particularly related to surgical procedures. Earlier in 1988 L&I had established and published admission criteria for the inpatient medical treatment of back pain (for those that did not require surgery). Within one year of publishing these criteria, medical back admissions for the department fell by 60 percent. Surprisingly, a statewide sentinel effect was also seen in hospital discharge data. The inpatient UR program was originally contracted to an out-of-state vendor who used proprietary surgical criteria to establish medical necessity. Although these criteria are used nationally by insurance companies, they were felt to be inadequate in detail and specificity for L&I's purpose of assuring quality.

The first OMD/WSMA medical guidelines subcommittee meeting occurred in September 1988, in response to an L&I request to assist with development of guidelines for lumbar fusion. After three to four months of meetings, the subcommittee, which included several prominent spine surgeons from the Seattle area, presented a draft of guidelines for fusion to the full OMD/WSMA committee. In 1989, L&I published the fusion guidelines. Since the publication of the medical back and fusion guidelines, 18 other guidelines have been established.

¹This work was done in full collaboration with the Washington State Medical Association Industrial Insurance Advisory Committee.

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The WSMA/L&I Medical Practice Guideline Process

The process used by the OMD/WSMA medical guidelines subcommittee is a combination of scientific evidence and community-based expert opinion. Although the consensus process is relatively informal, most aspects of the process for each guideline have been quite consistent, employing the following steps.

- Prioritization of guidelines
- Consensus development
- Formatting a decision-making algorithm
- Implementation
- Evaluation

PRIORITIZATION OF GUIDELINES

For the most part, prioritization has depended on 1) frequency of the problem, 2) cost, 3) poor outcomes or, 4) weak biologic plausibility. The lumbar fusion guideline, for example, was addressed first since no proprietary criteria for fusion were available. Other surgical guidelines were addressed because they are frequently performed (e.g., back, neck and knee). Both lumbar fusion and thoracic outlet surgery are relatively infrequent, but neither has strong clinical trial support nor clear biologic plausibility.

CONSENSUS DEVELOPMENT

Consensus development has generally taken place between the permanent members of the subcommittee (orthopedic surgeon, physiatrist, occupational medicine physician, neurologist, neurosurgeon) and *ad hoc* invited physicians who are clinical experts in the topic to be addressed. In order to reach consensus, the following assumptions are made.

1. The (surgical) guideline is meant to increase the proportion of surgical requests authorized for workers who truly require surgery, and to decrease the proportion of such authorizations among workers who do not fall within the consensus guideline.
2. The guideline is meant to be a gold standard for the majority of requests, but for the minority of workers who appear to fall outside of the guideline and whose complexity of clinical findings exceeds the specificity of the guideline, a further review by a specialty-matched physician is conducted.
3. The guideline is further refined after input from other community-based practicing physicians.
4. The guideline is evaluated to determine if it is having a beneficial effect.

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5. The guideline-setting process will be iterative, that is, although initial guidelines may be quite liberally constructed, subsequent tightening of the guideline would occur as other national guidelines are set, or other scientific evidence (e.g., from outcomes research) becomes available.

Assumption number two is particularly important and warrants elaboration. The intention of the OMD/WSMA medical guidelines subcommittee was to develop treatment guidelines that would be implemented in a nonadversarial way. The subcommittee tried to distinguish between clear-cut indications for procedures and indications that were questionable. The expectation was that when surgery was requested for a patient with clear-cut indications, the request would be approved by nurse consultants. However, if such clear-cut indications were not present, the request would not be automatically denied. Instead, it would be referred to a physician consultant who would review the patient's file, discuss the case with the requesting surgeon, and make recommendations to the claims manager. The flexibility built into this decision making process was important in two ways. First, it enabled the subcommittee to develop surgical indications fairly quickly, since the members were aware that the indications would not be applied in a heavy-handed way. Second, it played a major role in legitimizing the work of the subcommittee in the eyes of practicing physicians in Washington.

FORMATTING A DECISION MAKING ALGORITHM

Once the principles of the guideline are reached by consensus, these principles are placed in a format consisting of and/or statements intended to aid professional nurse reviewers in deciding whether a particular surgical request falls within the guideline.

IMPLEMENTATION

It has become clear that, without a method of implementation, medical practice guidelines may be inconsistently and informally applied. Most of the surgical guidelines established by OMD/WSMA have been implemented in the context of the inpatient UR program. It has been critical in contract negotiations with UR vendors to specify that the vendor is willing to substitute OMD/WSMA-generated guidelines for less specific standards already in use by the company. In 1994, the Department of Labor and Industries initiated an outpatient UR program, and this has allowed full implementation of guidelines related to outpatient procedures (e.g., carpal tunnel surgery, MRIs).

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EVALUATION

The Department is developing a database sufficient to provide continuous evaluation of all newly implemented guidelines. Current evaluation efforts, dependent on retrospective vendor reports, are labor intensive and are not responsive enough to emerging needs. The new database could identify both provider indicators of outlying behavior, as well as worker-based health outcomes (e.g., time loss duration post surgery).

GUIDELINE FOR HOSPITALIZATION FOR LOW BACK PAIN

The following guideline replaces Criteria for Non-Surgical Hospital Admission for Acute and Chronic Low Back Pain.

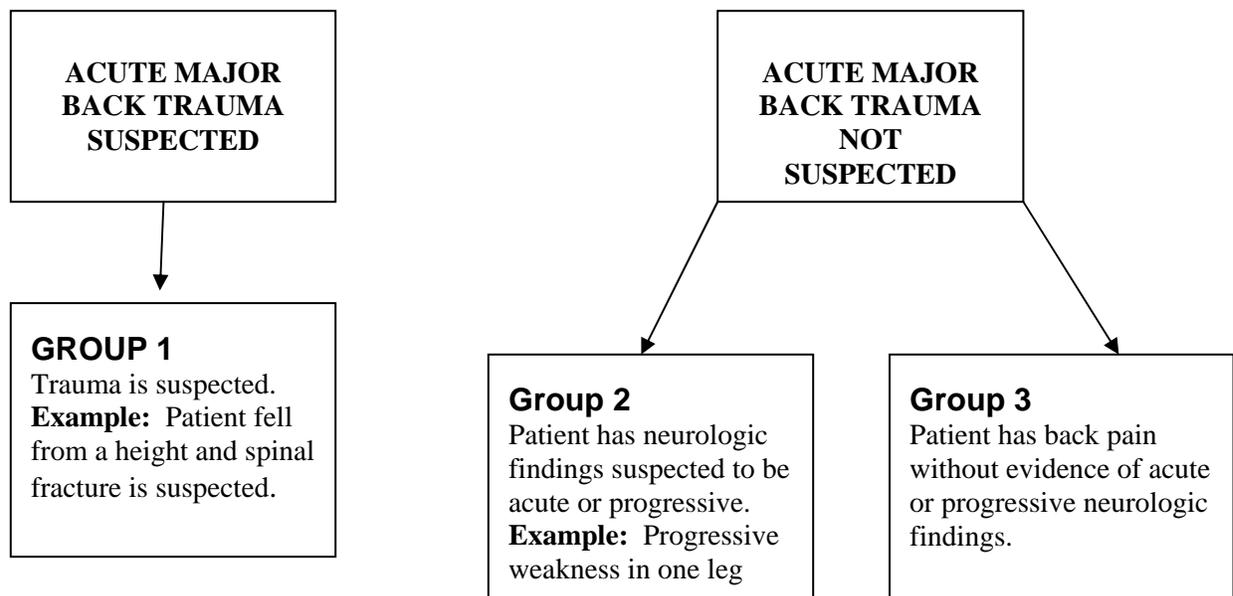
Changes in Practice Patterns:

Several years ago it was fairly common for physicians to hospitalize patients for medical management of low back pain. Typically, hospitalized patients were treated with bed rest, traction, and medication.

The frequency with which low back pain patients are hospitalized for medical management has dropped dramatically during the past ten years. This trend applies to both the injured worker population and other patient groups. For example, in 1986 there were approximately 1500 hospitalizations for medical management of low back pain among L&I patients; in 1996, the corresponding number was about 70.

The present guidelines reflect the current consensus that hospitalization is rarely needed for patients with low back pain.

CLASSIFICATION OF PATIENTS WITH LOW BACK PAIN



Guidelines for the management of these various groups or categories of medical problems are described on the following pages.

Date Introduced: June 1998

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CLINICAL FEATURES	PREADMISSION EVALUATION AND TREATMENT	HOSPITAL ADMISSION CRITERIA	POST-ADMISSION MANAGEMENT
<p>GROUP 1: Acute Major Trauma Suspected</p> <p>A) Back injury occurred within the past 7 days</p> <p style="text-align: center;">AND</p> <p>B) A major trauma was sustained (e.g. fall from a height, or back crushed by heavy object).</p> <p style="text-align: center;">AND</p> <p>C) Examining physician documents or suspects acute spinal fracture, spinal cord injury or nerve root injury.</p>	Individualized	Individualized	Individualized
<p>GROUP 2: Acute Major Back Trauma Not Suspected; Patient has Neurologic Findings Suspected to be Active or Progressive</p> <p>A) No history of recent major injury</p> <p style="text-align: center;">AND</p> <p>B) Patient complains of symptoms suggesting acute or progressive neurologic deficit. Typically these include:</p> <p>1) Progressive weakness or numbness in one leg (and occasionally both legs)</p> <p style="text-align: center;">OR</p> <p>2) Loss of control of bowel or bladder function</p> <p style="text-align: center;">OR</p> <p>3) Progressive numbness in the perineal region</p> <p style="text-align: center;">AND</p> <p>C) The examining physician indicates that the patient has (or probably has) an acute or progressive neurologic deficit</p>	<p>A) Outpatient setting: Evaluation and treatment is individualized.</p> <p>B) Emergency Department Setting:</p> <p>1) Advanced diagnostic imaging may be indicated when a patient in Group 2 comes to the Emergency Department.</p> <p>2) An attempt to reach the patient's attending physician should always be made before an emergency department MD decides to order advanced imaging studies. (The attending physician is in the best position to evaluate the patient's clinical presentation and judge the usefulness of imaging studies).</p> <p>3) If an imaging study is done and does NOT demonstrate an acute, lesion, for which surgery is indicated, the patient should be managed like a patient in Group 3. The patient should be discharged unless he/she is unable to perform ADLs at home.</p>	<p>A) If a patient has a new or progressive neurologic deficit, he/she may be hospitalized in order to facilitate surgical decision-making, to provide close observation of further progression or to help the patient compensate for neurological deficits (e.g. to determine whether the patient needs to learn intermittent catheterization).</p> <p>B) If a patient does NOT have a new or progressive neurologic deficit, he/she should be treated like a patient in Group 3. The only valid reason for hospitalization is that he/she cannot manage basic ADLs at home.</p> <p>C) If a patient is admitted through an emergency department, the decision to admit should be made with the concurrence of the attending physician, unless the attending physician cannot be reached.</p>	<p>A) <i>Duration of hospitalization should be brief.</i> The great majority of Group 2 patients who are admitted to a hospital can be discharged in 1-3 days (if spine surgery is not performed).</p> <p>B) Treatment Plan Goals</p> <p>1) General Strategy – It is crucial to assess the patients' ability to perform ADLs and to identify environmental barriers to return home.</p> <p>a) An assessment of these factors should begin immediately upon admission. A list of barriers to discharge should be noted in the patient record.</p> <p>b) The ability of the patient to perform ADLs should be measured serially, e.g., can the patient ambulate to the bathroom?</p> <p>c) Discharge planning should begin immediately, for example: the patient's significant other should be contacted and problem solving should be undertaken regarding practical problems such as the ability to get food and ambulate to the bathroom in the home.</p> <p>2) Pain Management – Review potential to benefit</p>

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CLINICAL FEATURES	PREADMISSION EVALUATION AND TREATMENT	HOSPITAL ADMISSION CRITERIA	POST-ADMISSION MANAGEMENT
			<p>from nonsteroidals, antidepressants, opiates. NOTE: The Department of Labor and Industries does not cover epidural or intrathecal administration of opiates except in the peri-operative period.</p> <p>3) Management of Neurological Deficits – a patient may need help with bladder catheterization or may need a brace for his/her leg.</p> <p>C) Diagnostic Imaging, Physician Consultants and Surgical Planning – Individualized.</p> <p>D) NOTE: Prolonged bed rest usually does more harm than good in a patient with low back pain. Admission for the purpose of bed rest is not acceptable.</p>
<p>GROUP 3: Acute Major Back Trauma Not Suspected; Patient Has Back Pain Without Evidence of Acute or Progressive Neurologic Findings</p> <p>A) No history of recent major trauma.</p> <p style="text-align: center;">AND</p> <p>B) Patient complains of back pain with or without symptoms in the legs. Occasionally patients will complain mainly of symptoms in the legs but the evaluating physician concludes that symptoms are not caused by lumbar radiculopathy</p> <p style="text-align: center;">AND</p> <p>C) No evidence of acute or progressive neurologic deficit.</p>	<p>A) When the attending physician initiates hospitalization from an outpatient setting:</p> <p>1) The attending physician must document that he/she has given the patient an adequate trial of oral medication to control pain and that the patient has made a genuine attempt to manage ADLs at home.</p> <p>B) When hospitalization is initiated from an emergency room: NOTE: most admissions for back pain start with an injured worker going to the emergency department.</p> <p>1) Advanced imaging is RARELY indicated. Advanced imaging should be ordered ONLY with the concurrence or the patient's attending physician.</p>	<p>A) The only valid reason for hospitalizing a patient is that he/she cannot manage basic ADLs at home. Example, the patient lives alone and is unable to get to the bathroom.</p> <p>B) If a patient is admitted through the emergency department, the decision to admit should be made with the concurrence of the attending physician, unless the attending physician cannot be reached.</p>	<p>A) <i>Duration of hospitalization should be brief.</i> The great majority of Group 3 patients who are admitted to a hospital can be discharged in less than 24 hours.</p> <p>B) <i>Treatment Plan Goals</i></p> <p>1) General Strategy – It is crucial to assess the patient's ability to perform ADLs and to identify environmental barriers to return to the home.</p> <p>a) An assessment of these factors should begin immediately upon admission. A list of barriers to discharge should be noted in the patient record</p> <p>b) The ability of the patient to perform ADLs should be measured serially – e.g., can the patient ambulate to the bathroom?</p> <p>c) Discharge planning should begin immediately, for example: the patient's significant other should be contacted and problem solving should be undertaken regarding</p>

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CLINICAL FEATURES	PREADMISSION EVALUATION AND TREATMENT	HOSPITAL ADMISSION CRITERIA	POST-ADMISSION MANAGEMENT
			<p>practical problems such as the ability to get food and ambulate to the bathroom in the home.</p> <p>2) Pain Management – Review potential to benefit from nonsteroidals, antidepressants, opiates. NOTE: The Department of Labor and Industries does not cover epidural or intrathecal administration of opiates except in the peri-operative period). Physical Activity – The patient should receive aggressive physical therapy at least twice per day.</p> <p>3) Diagnostic Imaging and Physician Consultants a) These rarely need to be done while a patient is in the hospital. b) The patient’s hospital stay should not be prolonged simply to facilitate imaging or consultation while he/she is still in the hospital. The patient should be discharged as soon as he/she is able to manage basic ADLs. Imaging and consultation can be done as an outpatient.</p> <p>C) NOTE: Admission for the purpose of bed rest or traction alone is not acceptable.</p> <p>D) A patient should not be admitted to a hospital that does not have the capacity to assess ADLs, develop a treatment plan, & provide physical therapy within the first 24 hours.</p>

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Cauda Equina

PROCEDURE	CONSERVATIVE CARE	Clinical Findings		
		SUBJECTIVE	OBJECTIVE	IMAGING
LUMBAR: LAMINECTOMY, DISCECTOMY,	Not Applicable	Sudden onset or rapid progression of sensory symptoms	AND Acute Progressive neurological deficit that is either bilateral or involves multiple neurological levels	AND Demonstrates a large lesion producing central stenosis with tight obstruction Tests include: CT Scan OR MRI OR Myelogram

Date Introduced: January 1991

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Review Criteria for Knee Surgery

PROCEDURE	CONSERVATIVE CARE	Clinical Findings		
		SUBJECTIVE	OBJECTIVE	CARE
ANTERIOR CRUCIATE LIGAMENT (ACL) REPAIR	(Not required for acute injury with hemarthrosis) Physical therapy OR Brace	AND	AND	AND
		Pain alone is not an indication for surgery Instability of the knee, described as "buckling or give way" OR Significant effusion at the time of injury OR Description of injury indicates rotary twisting or hyperextension incident	Positive Lachman's sign OR Positive pivot shift OR Positive anterior drawer OR Positive KT 1000 >3-5 mm = +1 >5-7 mm = + 2 >7 mm = +3	(Not required if acute effusion, hemarthrosis, and instability; or documented history of effusion, hemarthrosis, and instability) ACL disruption on: MRI OR Arthroscopy OR Arthrogram
LATERAL RETINACULAR RELEASE OR PATELLAR TENDON REALIGNMENT OR MAQUET PROCEDURE	Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture) OR Medications	AND	AND	AND
		Knee pain with sitting OR Pain with patellar/femoral movement OR Recurrent dislocations	Lateral tracking of the patella OR Recurrent effusion OR Patellar apprehension OR Synovitis with or without crepitus OR Increased Q angle > 15 degrees	Abnormal patellar tilt on: X-ray, CT, or MRI

Reference: Provider Bulletin 03-16; Date Introduced: December 2003

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PROCEDURE	CONSERVATIVE CARE	Clinical Findings		
		SUBJECTIVE	OBJECTIVE	IMAGING
KNEE JOINT REPLACEMENT If only 1 compartment is affected, a unicompartmental or partial replacement is indicated. If 2 of the 3 compartments are affected, a total joint replacement is indicated.	Medications OR Visco supplementation injections OR Steroid injection	AND	AND	AND
		Limited range of motion OR Night time joint pain OR No pain relief with conservative care	Over 50 years of age AND Body Mass Index of less than 35	Osteoarthritis on: Standing x-ray OR Arthroscopy

PROCEDURE	CONSERVATIVE CARE	SUBJECTIVE	OBJECTIVE	IMAGING
DIAGNOSTIC ARTHROSCOPY	Medications OR Physical therapy	AND		AND
		Pain and functional limitations continue despite conservative care		Imaging is inconclusive
MENISCECTOMY OR MENISCUS REPAIR	(Not required for locked/blocked knee) Physical therapy OR Medication OR Activity modification	AND	AND	AND
		Joint pain OR Swelling OR Feeling of give way OR Locking, clicking, or popping	Positive Mc Murray's sign OR Joint line tenderness OR Effusion OR Limited range of motion OR Locking, clicking, or popping OR Crepitus	(Not required for locked/blocked knee) Meniscal tear on MRI

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PROCEDURE	CONSERVATIVE CARE	SUBJECTIVE	OBJECTIVE	IMAGING
CHONDROPLASTY (Shaving or debridement of an articular surface)	Medication OR Physical therapy	Joint pain AND Swelling	Effusion OR Crepitus OR Limited ROM	
SUBCHONDRAL DRILLING OR MICROFRACTURE	Medication OR Physical therapy	Joint pain AND Swelling	Small full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle AND Knee is stable with intact, fully functional menisci and ligaments AND Normal knee alignment AND Normal joint space AND Ideal age 45 or younger	Chondral defect on the weight bearing portion of the medial or lateral femoral condyle on: MRI OR Arthroscopy

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PROCEDURE	CONSERVATIVE CARE	SUBJECTIVE	OBJECTIVE	IMAGING
OSTEOCHONDRAL AUTOGRAFT (MOSAICPLASTY OR OATS PROCEDURE)	Medication OR Physical therapy	AND Joint pain AND Swelling	AND Failure of previous subchondral drilling or microfracture Large full thickness chondral defect that measures less than 3 cm in diameter and 1 cm in bone depth on the weight bearing portion of the medial or lateral femoral condyle AND Knee is stable with intact, fully functional menisci and ligaments AND Normal knee alignment AND Normal joint space AND Body mass index of less than 35	AND Chondral defect on the weight bearing portion of the medial or lateral femoral condyle on: MRI OR Arthroscopy

Body Mass Index

The equation for calculating the Body Mass Index (BMI) = (Weight in pounds ÷ Height in inches ÷ Height in inches) x 703. For example, a person weighing 210 pounds and 6 feet tall would have a BMI of (210 pounds ÷ 72 inches ÷ 72 inches) x 703 = 28.5.

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PROCEDURE	CONSERVATIVE CARE	SUBJECTIVE	OBJECTIVE	IMAGING
AUTOLOGOUS CHONDROCYTE IMPLANTATION (ACI)	Physical therapy for a minimum of 2 months	<p style="text-align: center;">AND</p> IW is capable and willing to follow the rehabilitation protocol.	<p style="text-align: center;">AND</p> Failure of traditional surgical interventions (i.e., microfracture, drilling, abrasion, osteochondral graft). Debridement alone does not constitute a traditional surgical intervention for ACI <p style="text-align: center;">AND</p> Single, clinically significant, lesion that measures between 1 to 10 sq.cm in area that affects a weight-bearing surface of the medial femoral condyle or the lateral femoral condyle. <p style="text-align: center;">AND</p> Full-thickness lesion (Modified Outerbridge Grade III-IV) that involves only cartilage. <p style="text-align: center;">AND</p> Knee is stable with intact, fully functional menisci and ligaments. <p style="text-align: center;">AND</p> Normal knee alignment <p style="text-align: center;">AND</p> Normal joint space. <p style="text-align: center;">AND</p> IW is less than 60 years old <p style="text-align: center;">AND</p> Body Mass Index of less than 35.	<p style="text-align: center;">AND</p> Chondral defect on the weight bearing surface of the medial or lateral femoral condyle on: MRI OR Arthroscopy

ACI EXCLUSION CRITERIA

ACI is not a covered procedure in **any** of the following circumstances:

- Lesion that involves any portion of the patellofemoral articular cartilage, bone, or is due to osteochondritis dissecans.
- A “kissing lesion” or Modified Outerbridge Grade II, III, or IV exists on the **opposite** tibial surface.
- Mild to severe localized or diffuse arthritic condition that appears on standing x-ray as joint space narrowing, osteophytes, or changes in the underlying bone.
- Unhealthy cartilage border; the synovial membrane in the joint may be used as a substitute border for up to ¼ of the total circumference.
- Prior total meniscectomy of either compartment in the affected knee. Must have at least 1/3 of the posterior meniscal rim.
- History of anaphylaxis to gentamycin or sensitivity to materials of bovine origin.
- Chondrocalcinosis is diagnosed during the cell culture process.

Modified Outerbridge Classification

I	Articular cartilage softening
II	Chondral fissures or fibrillation < 1.25 cm in diameter
III	Chondral fibrillation > 1.25 cm in diameter, (“crabmeat changes”)
IV	Exposed subchondral bone

Please refer to Provider Bulletin 03-02 for additional coverage information. Surgeon should have performed or assisted in 5 or more ACI procedures; or will be performing the ACI under the direct supervision and control of a surgeon who has experience with 5 ACI procedures.

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INCLUSION CRITERIA

PROCEDURE	CONSERVATIVE CARE	SUBJECTIVE	OBJECTIVE	IMAGING
MENISCAL ALLOGRAFT TRANSPLANTATION	Physical therapy OR NSAID OR Activity modification	<p style="text-align: center;">AND</p> Capable and willing to follow the rehabilitation protocol. <p style="text-align: center;">AND</p> Knee pain that has not responded to conservative treatment.	<p style="text-align: center;">AND</p> Previous meniscectomy with at least two-thirds of the meniscus removed. <p style="text-align: center;">AND</p> If Modified Outerbridge Scale Grade III then debridement must first produce an articular surface sufficiently free of irregularities to maintain the integrity of the transplanted meniscus. <p style="text-align: center;">AND</p> Stable knee with intact ligaments, normal alignment, and normal joint space. <p style="text-align: center;">AND</p> Ideal age 20-45 years (too young for total knee) <p style="text-align: center;">AND</p> Body Mass Index of less than 35	<p style="text-align: center;">AND</p> Articular cartilage in the affected compartment demonstrates a chondrosis classified by the Modified Outerbridge Scale as Grade I, Grade II, or Grade III.

MENISCAL ALLOGRAFT TRANSPLANTATION EXCLUSION CRITERIA

Meniscal Allograft Transplantation is not a covered procedure in **any** of the following circumstances:

- Mild to severe localized or diffuse arthritic condition that appears on standing x-ray as joint space narrowing, osteophytes, or changes in the underlying bone.
- Articular cartilage in the affected compartment demonstrates a chondrosis classified by the Modified Outerbridge Scale as Grade III that has not undergone debridement; Grade III with debridement that has not produced an articular surface that can maintain the integrity of the transplanted meniscus; or Grade IV.

Please refer to Provider Bulletin 03-02 for additional coverage information. Surgeon should have performed or assisted in 5 or more meniscal allograft transplantation procedures; or will be performing the meniscal allograft transplantation under the direct supervision and control of a surgeon who has experience with 5 procedures.

Modified Outerbridge Classification

I	Articular cartilage softening
II	Chondral fissures or fibrillation < 1.25 cm in diameter
III	Chondral fibrillation > 1.25 cm in diameter, ("crabmeat changes")
IV	Exposed subchondral bone

Body Mass Index

The equation for calculating the Body Mass Index (BMI) = (Weight in pounds ÷ Height in inches ÷ Height in inches) x 703. For example, a person weighing 210 pounds and 6 feet tall would have a BMI of (210 pounds ÷ 72 inches ÷ 72 inches) x 703 = 28.5

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Review Criteria for Cervical Surgery for Entrapment of a Single Nerve Root

PROCEDURE	CONSERVATIVE CARE	Clinical Findings		
		SUBJECTIVE	OBJECTIVE	IMAGING
CERVICAL DISCECTOMY LAMINECTOMY LAMINOTOMY FORAMINOTOMY WITH OR WITHOUT FUSION EXCLUDING FRACTURES	6-8 weeks of: Physical therapy OR Medications OR Cervical traction	AND Sensory symptoms in a dermatomal distribution that correlates with involved cervical level (1) OR Positive Spurling test	AND Motor deficit OR Reflex changes OR Positive EMG Changes should correlate with involved cervical level	AND Abnormal imaging that correlates nerve root involvement with subjective and objective findings, on: Myelogram with CT scan OR MRI
	A positive response to Selective Nerve Root Block (2) that correlates with imaging abnormality is required if there are complaints of radicular pain with no motor, sensory, reflex or EMG changes.			

Relative Contraindication: current cigarette smoking. See Provider Bulletin 03-13 for a description of the department's coverage policy on smoking cessation prior to spinal fusion.

Cases to be referred for physician review include:

- Repeat surgery at the same level
- Request for surgery at C3-4 level or above
- Objective findings indicating myelopathy

When requesting authorization for decompression of multiple nerve roots levels, each level is subject to the review criteria.

- (1) Sensory deficit, motor weakness, and reflex changes may vary depending on innervation.
- C4-5 disc herniation with compression of C5 nerve root may produce sensory deficit in the lateral upper arm and elbow; motor weakness in the deltoid and variably in the biceps (elbow flexion); and reflex changes variably in the biceps.
 - C5-6 disc herniation with compression of the C6 nerve root may produce sensory deficit in the radial forearm, thumb, and index finger; motor weakness in the biceps, forearm supination, and wrist extension; and reflex changes in the biceps and brachioradialis.
 - C6-7 disc herniation with compression of the C7 nerve root may produce sensory deficit in the index and middle fingers; motor weakness in the triceps (elbow extension), wrist flexion, and variably in the finger flexors; and reflex changes in the triceps.
- (2) A selective nerve root block may be considered "positive" if it:
- Initially produces pain in the distribution of the nerve root being blocked, and
 - Produces at least 75% reduction in pain for a duration consistent with the type of local anesthetic used for the block.

Reference: Provider Bulletin 04-10; Date Introduced: June 2004

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Criteria for Entrapment of a Single Lumbar Nerve Root

PROCEDURE	CONSERVATIVE CARE	Clinical Findings		
		SUBJECTIVE	OBJECTIVE	IMAGING
LUMBAR: LAMINECTOMY, LAMINOTOMY, DISCECTOMY, MICRO- DISCECTOMY, FORAMINOTOMY	Failure to improve with four weeks minimum For example: - Physical therapy - Non-steroidal anti-inflammatory agents - Traction	Sensory symptoms in dermatomal AND distribution may include: Radiating pain, burning, numbness, tingling or paresthesia of lower extremity	Dermatomal sensory deficit OR Motor deficit (e.g., foot drop or quadriceps weakness) OR Reflex changes OR Positive EMG	Abnormal test results that correlate with the level of nerve root involvement consistent with subjective and objective findings. Tests include: CT Scan OR MRI OR Myelogram
<p>Requests for authorization to treat lateral or central spinal stenosis not accompanied by nerve root entrapment or the necessity of arthrodesis will be reviewed by a Physician Adviser.</p>				

Date Introduced: March 1992

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Criteria for Ankle/Foot

PROCEDURE	CONSERVATIVE	Clinical Findings		
	CARE	SUBJECTIVE	OBJECTIVE	IMAGING
<p>FUSION - ANKLE - TARSAL - METATARSAL TO TREAT NON- OR MAL-UNION OF A FRACTURE</p> <p style="text-align: center;">OR</p> <p>TRAUMATIC ARTHRITIS SECONDARY TO ON THE JOB INJURY TO THE AFFECTED JOINT</p>	<p>Immobilization AND Pain including which may include: that which is aggravated by activity and weight-bearing</p> <p>Casting, bracing, shoe modification or other orthotics</p> <p style="text-align: center;">OR</p> <p>Anti-inflammatory medications</p> <p style="text-align: center;">AND</p> <p>Relieved by Xylocaine injection</p>	<p style="text-align: center;">AND</p> <p style="text-align: center;">AND</p>	<p>Malalignment AND</p> <p style="text-align: center;">AND</p> <p>Decreased range of motion</p>	<p>Positive x-ray confirming presence of:</p> <p>- Loss of articular cartilage (arthritis)</p> <p style="text-align: center;">OR</p> <p>- Bone deformity (hypertrophic spurring, sclerosis)</p> <p style="text-align: center;">OR</p> <p>- Non or mal-union of a fracture</p> <p>Supportive imaging could include:</p> <p>Bone scan (for arthritis only) to confirm localization</p> <p style="text-align: center;">OR</p> <p>MRI</p> <p style="text-align: center;">OR</p> <p>Tomography</p>
	<p>- Requests for intertarsal or subtalar fusion will be referred to Physician Adviser</p>			

Date Introduced: March 1992

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Criteria for Ankle Continued

PROCEDURE	CONSERVATIVE CARE	Clinical Findings		
		SUBJECTIVE	OBJECTIVE	IMAGING
<p>LATERAL LIGAMENT ANKLE RECONSTRUCTION FOR CHRONIC INSTABILITY OR ACUTE SPRAIN/STRAIN INVERSION INJURY</p>	<p>Physical Therapy - immobilization with support cast or ankle brace</p> <p>- Rehab program</p> <p>For either of the above, time frame will be variable with severity of trauma</p>	<p>For chronic: AND</p> <p>- Instability of the ankle</p> <p>Supportive findings:</p> <p>- Complaint of swelling</p> <p>For acute:</p> <p>- Description of an inversion</p> <p style="text-align: center;">AND/OR</p> <p>Hyperextension injury, ecchymosis, swelling</p>	<p>For chronic: AND</p> <p>Positive anterior drawer</p> <p>For acute:</p> <p>- Grade 3 injury (lateral injury)</p> <p style="text-align: center;">AND/OR</p> <p>Osteochondral fragment</p> <p style="text-align: center;">AND/OR</p> <p>Medial incompetence</p> <p style="text-align: center;">AND</p> <p>Positive anterior drawer</p>	<p>Positive stress x-rays identifying motion at ankle or subtalar joint. At least 15° lateral opening at the ankle joint.</p> <p style="text-align: center;">OR</p> <p>Demonstrable subtalar movement</p> <p style="text-align: center;">AND</p> <p>Negative to minimal arthritic joint changes on x-ray</p>
	<p>- Requests to use prosthetic ligaments will not be authorized</p> <p>- Requests for any plastic implant will be referred to a Physician Adviser for review</p> <p>- Requests for calcaneous osteotomies will be referred to a Physician Adviser for review</p>			

Criteria for MRI of the Lumbar Spine

INDICATIONS FOR MRI OF THE LUMBAR SPINE

- Any neurologic deficit, evidence of radiculopathy, cauda equina compression (e.g., sudden bowel/bladder disturbance).

OR

- Suspected systemic disorder, i.e., to r/o metastatic or infectious disease.

OR

- Localized back pain with no radiculopathy (leg pain), clinical history of lumbar sprain or strain, and failed 6-week course of conservative care.

INDICATIONS FOR REPEAT MRI OF THE LUMBAR SPINE

- Significant change in clinical finding, i.e., new or progressive neurological deficit.

NOTE: The primary physician is strongly encouraged to coordinate with a subspecialist: i.e., a board certified spine specialist, orthopedist or radiologist, before ordering a repeat MRI of the lumbar spine.

Date Introduced: January 1994

Medical Treatment Guidelines

Criteria for Shoulder Surgery

A request may be appropriate for ↓	If the patient has ↓	AND the diagnosis is supported by ↓			AND this has been done (if recommended) ↓
SURGICAL PROCEDURE	DIAGNOSIS	CLINICAL FINDINGS			CONSERVATIVE CARE
		SUBJECTIVE	OBJECTIVE	IMAGING	
Rotator cuff repair (CPT 23410, 23412, 23420)	Full Thickness Rotator Cuff Tear AND Cervical pathology and frozen shoulder syndrome have been ruled out	Shoulder pain and inability to elevate the arm; Tenderness over the greater tuberosity is common in acute cases	Patient may have weakness with abduction testing; May also demonstrate atrophy of shoulder musculature; Usually has full passive range of motion.	Conventional x-rays, AP, and true lateral or axillary view AND Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff	Not required
Rotator cuff repair CPT 23410, 23412, or 23420) OR Anterior acromioplasty ¹ (CPT 23130, 23415, 29826)	Partial Thickness Rotator Cuff Repair OR Acromial Impingement Syndrome (80% of these patients will get better without surgery) ¹	Pain with active arc motion 90-130 ° AND Pain at night; Tenderness over the greater tuberosity is common in acute cases.	Weak or absent abduction. May also demonstrate atrophy AND Tenderness over rotator cuff or anterior acromial area AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test)	Conventional x-rays, AP, and true lateral or axillary view AND Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff	Recommend 3-6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature.
Treatment of acromioclavicular dislocation, acute or chronic (CPT 23550)	Shoulder AC Joint Separation	Pain with marked functional difficulty	Marked deformity	Conventional x-rays Show Grade III+ separation	Recommend at least 3 months. Most patients with grade III AC dislocations are best treated non-operatively.
Partial claviclectomy (includes Mumford procedure) (CPT 23120, 29824)	Post traumatic Arthritis of AC Joint	Pain at AC joint; aggravation of pain with shoulder motion or carrying weight OR Previous Grade I or II AC separation	Tenderness over the AC joint; Most symptomatic patients with partial AC joint separation have a positive bone scan AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial	Conventional films show either: (a) Post traumatic changes of AC joint, OR (b) Severe DJD of AC joint, OR (c) Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation	At least 6 weeks of care directed toward symptom relief prior to surgery. Surgery is not indicated before 6 weeks.

¹ Neer, C. S. Anterior acromioplasty for the chronic impingement syndrome in the shoulder: a preliminary report. Journal of Bone & Joint Surgery, American Volume. 54(1):41-50, 1972 (Jan.)

Reference: Provider Bulletin 02-01; Date Introduced: March 2002

Medical Treatment Guidelines

Criteria for Shoulder Surgery -- Continued

A request may be appropriate for ↓	If the patient has ↓	AND the diagnosis is supported by ↓			AND this has been done (if recommended) ↓
SURGICAL PROCEDURE	DIAGNOSIS	CLINICAL FINDINGS			CONSERVATIVE CARE
		SUBJECTIVE	OBJECTIVE	IMAGING	
Capsulorrhaphy or Bankart procedure (CPT 23450, 23455, 29806)	Recurrent Glenohumeral Dislocations	History of multiple dislocations that inhibit activities of daily living	At least one of the following: Positive apprehension findings; OR Injury to the humeral head; OR Documented dislocation under anesthesia	Conventional x-rays, AP and true lateral or axillary view	None required
Tenodesis of Long Head of Biceps (CPT 23430) Consideration of tenodesis should include the following: Patient should be a young adult; Not recommended as an independent stand alone procedure There must be evidence of an incomplete tear	<u>Incomplete</u> Tear or raying of the Proximal Biceps Tendon The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review	Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery.	Partial thickness tears do not have the classical appearance of ruptured muscle.	Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP, and true lateral or axillary view AND Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff	None required
Tenodesis of Long Head of Biceps (CPT 23430)	<u>Complete</u> Tear of the Proximal Biceps Tendon	Pain, weakness, and deformity	Classical appearance of ruptured muscle.	Not required	Surgery almost never considered in full thickness ruptures.
Reinsertion of Ruptured Biceps Tendon (CPT 24342)	Distal Rupture of the Biceps Tendon	All should be repaired within 2-3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed.			
Diagnostic Arthroscopy (CPT 29805)	Shoulder Arthroscopy for Diagnostic Purposes	Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. Requests for authorization of this procedure in the inpatient setting will be reviewed by a peer physician. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear.			

Guidelines For Lumbar Fusion (Arthrodesis)

I. The purpose of the guidelines are:

- A. To serve as an instructional aid for physicians when treating injured workers who present with low back pain and associated symptoms that have developed in the context of routine work activity, and who have no evidence of spinal fracture.
- B. To provide utilization review nurses with the information necessary to make recommendations about the medical necessity and clinical appropriateness of spinal fusions.

Exception: These guidelines do not apply to requests for fusion to treat patients with a spinal fracture or dislocation, spinal infection, or spinal deformity, (e.g. one related to degenerative scoliosis).

II. Conservative care (consisting of all the following) should be tried first.

- A. The patient should have at least three months of conservative therapy for low back pain, which predominantly emphasizes physical reconditioning.
- B. The surgeon requesting the lumbar fusion should have personally evaluated the patient on at least two occasions prior to requesting the fusion.

Exception: If the patient has a progressive neurological deficit, both A and B above can be waived.

III. If conservative care has failed to relieve symptoms and the patient has had no prior surgery, lumbar fusions should be considered only if the patient has one or more of the following:

- A. Mechanical (non-radicular) low back pain with instability;

Instability of the lumbar segment is defined as at least 4mm of anterior/posterior translation at L3-4 and L4-5, or 5mm of translation at L5-S1 or 11 degrees greater end plate angular change at a single level, compared to an adjacent level. Adequate flexion/extension views should be taken utilizing techniques that minimize the potential contribution of hip motion to perceived lumbar flexion or extension.

Note: Only single level fusions will be approved for patients with no prior spinal surgery.

Reference: Provider Bulletin 01-05; Date Introduced: June 2001

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B. Spondylolisthesis exists with one or more of the following:

1. Objective signs/symptoms of neurogenic claudication *OR*
2. Objective signs/symptoms of unilateral or bilateral radiculopathy, which are corroborated by neurologic examination and by MRI or CT (with or without myelography) *OR*
3. Instability of the lumbar segment as defined above in section III-A.

IV. If conservative care has failed to relieve symptoms and the patient has had a prior laminectomy, diskectomy, or other decompressive procedure at the same level, lumbar fusion should be considered only if the patient has one or more of the following:

- A. Mechanical (non-radicular) low back pain with instability (as defined above in Section III-A) at the same or adjacent levels *OR*
- B. Mechanical (non-radicular) low back pain with pseudospondylolisthesis, rotational deformity or other condition leading to a progressive (measurable) deformity *OR*
- C. Objective signs/symptoms compatible with neurogenic claudication or lumbar radiculopathy that is supported by MRI or CT (with or without myelography) and by a detailed clinical neurological examination *OR*
- D. Evidence from a post-laminectomy structural study of either:
 1. 100% loss of facet surface area unilaterally, *OR*
 2. 50% combined loss of facet surface area bilaterally

V. If conservative care has failed to relive symptoms and the patient has had a prior fusion at the same level, lumbar fusion should be considered only if the patient has one or more of the following:

- A. Psuedarthrosis with or without hardware failure, confirmed by objective evidence of pseudarthrosis (e.g. abnormal thin slice CT scan)
- B. Neurogenic claudication supported by either MRI, CT, or myelography
- C. Lumbar radiculopathy supported by either MRI, CT, or myelography, or supported by a detailed clinical neurological or neurosurgical examination.

VI. If conservative care has failed to relieve symptoms and the patient has had a prior fusion at a level adjacent to the new one being considered, lumbar fusion should be considered only if the patient meets the same criteria as described for patients with no prior history of spine surgery (see section III above).

VII. Contraindications for lumbar fusions, even when patients meet the criteria described in sections III, IV, V, and VI above.

- A. Absolute contraindications
 1. Lumbar fusion is not indicated with an initial laminectomy/diskectomy related to unilateral compression of a lumbar nerve root.

Medical Treatment Guidelines

- B. Relative contraindications
 - 1. Severe physical de-conditioning
 - 2. Current smoking
 - 3. Multiple level degenerative disease of the lumbar spine
 - 4. Greater than 12 months of disability (time-loss compensation benefits) prior to consideration of fusion
 - 5. No evidence of functional recovery (return to work) for at least six months following the most recent spine surgery
 - 6. Psychosocial factors that are correlated with poor outcome, such as:
 - a. History of drug or alcohol abuse
 - b. High degrees of somatization on clinical or psychological evaluation
 - c. Presence of a personality disorder or major psychiatric illness
 - d. Current evidence of factitious disorder

VII. When the physician wants to proceed with a lumbar fusion request:

- A. The physician should be aware of the following research based findings*:
 - 1. The chance of an injured worker no longer being disabled 2 years after lumbar fusion is only 32%.d
 - 2. More than 50% of workers who received lumbar fusion through the Washington workers' compensation program felt that both pain and functional recovery were no better or worse after lumbar fusion.
 - 3. The overall rate of re-operation within 2 years for all fusions is approximately 23%.
 - 4. Smoking at the time of fusion greatly increases the risk of pseudarthrosis.
 - 5. Pain relief, even when present, is not likely to be complete.
 - 6. The use of spine stabilization hardware (metal devices) in Washington workers nearly doubled the chances of having another surgery.
- B. The operating surgeon should follow the lumbar fusion patient at least every two months for the first six postoperative months. At the six month examination, if the patient is still experiencing significant pain, a face to face evaluation should be conducted, which includes all of the following elements:
 - 1. Neurologic examination
 - 2. This slice CT to rule out pseudarthrosis
 - 3. Repeat flexion-extension films to rule out instability (as defined in III-A)

If new objective neurologic signs are absent, and if there is no objective evidence of fusion failure, the patient may have reached maximum medical improvement and an impairment rating (permanent partial disability (PPD) assessment) may be appropriate.

- C. Prior to lumbar fusion, clinical psychological or psychiatric assessment should be performed on all patients who meet the lumbar fusion criteria and who have been receiving time-loss compensation benefits.

Medical Treatment Guidelines

- This assessment is intended to help the requesting surgeon identify specific psychological risk factors for chronic disability that may be barriers to recovery following lumbar fusion.
- D. All intraoperative determinations of instability that lead to fusion must be clearly documented at the time, and (if requested by L&I) subsequently discussed with a peer surgeon.
 - E. Although adding to the clinical database, provocative discography, diagnostic facet joint injections, and pain relief during the use of a rigid spinal brace are not definitive indications for fusion.
 - F. Anterior Lumbar Interbody Fusion (ALIF), if indicated, should be done only in conjunction with a posterior stabilization procedure.

Note: Prior to surgery, the physician should discuss with the patient, the information provided on the attached form (see next page). After discussing these details, both the physician and patient should sign at the bottom of the form. The form should be kept in the patient's medical records at the requesting surgeon's office.

Medical Treatment Guidelines

What You Should Know About Lumbar Fusion Surgery

Labor & Industries (the department) has created this information form so you will know how lumbar fusion surgery may affect your health and recovery. The department requires your doctor to discuss this information with you before the surgery in order to make the best decision possible. After you have read and discussed this information, both you and your doctor should sign your names at the end of this form. **This is NOT a surgical consent form.**

A study* conducted by Labor & Industries at the University of Washington showed that in Washington workers:

- About 2/3 of the workers who receive a lumbar fusion are still disabled two years after the surgery.
- More than half of the workers who received lumbar fusion felt that both their pain and ability to function were no better or worse after the surgery.
- Almost one quarter of the workers who had fusion surgery were operated on again within two years.
- Smoking at the time of fusion greatly increases the risk of failed fusion.
- The use of spine stabilization hardware (metal devices) in Washington workers nearly doubled the chances of having another surgery.
- Pain relief, even when present, is not likely to be complete.

In addition:

- Smoking at the time of fusion greatly increases the risk of fusion failure.
- Pain relief after fusion, even when it occurs, is not likely to be complete.

You should also know the department's expectations:

If the department approves your surgery, I will continue to see you at least every two months for six months after the surgery. If your fusion is successful (as defined in section VIII-B of the guidelines), I will consider you to be stable and will ask for an impairment rating to complete your care. If you continue to have pain after your surgery and I cannot find a medical reason for it, the department may not continue to pay for your medical care.

By signing this form, we (the *patient* and *physician*), attest that we have discussed the information presented here, we understand this information, and we wish to proceed with the fusion procedure. **We also understand that this information does NOT take the place of, and is separate and distinct from, the surgical consent form that we will review and sign prior to surgery.**

Patient Name
Date: ____/____/____

Physician Name
Date: ____/____/____

* Gary Franklin, MD, et. al., "Outcomes of Lumbar Fusion in Washington State Workers' Compensation" SPINE 1994, Vol 9, No. 17, pp. 1897 – 1903.

Medical Treatment Guidelines

Surgery for Thoracic Outlet Syndrome (TOS)

TYPE OF TOS	SUBJECTIVE	OBJECTIVE	IMAGING
VASCULAR TOS ARTERIAL	At least three of AND the following must be present in the affected upper extremity: A. Pain B. Swelling or heaviness C. Decreased temperature or change in color D. Paresthesias in the ulnar nerve distribution	At least one of the AND following: A. Pallor or coolness B. Gangrene of the digits in advanced cases	C. Abnormal arteriogram
.....			
VASCULAR TOS VENOUS	At least three of AND the following must be present in the affected upper extremity: A. Pain B. Swelling or heaviness C. Decreased temperature or change in color D. Paresthesias in the ulnar nerve distribution	At least two of the AND following: A. Swelling of the arm, B. Venous engorgement C. Cyanosis	D. Abnormal venogram
.....			
NEUROGENIC TOS	In the affected AND upper extremity: A. Pain and B. Numbness or paresthesia in the ulnar nerve distribution	In the affected upper extremity, all of the following electrodiagnostic abnormalities must be found: A. Reduced amplitude median motor response and B. Reduced amplitude ulnar sensory response and C. Denervation in muscles innervated by lower trunk of the brachial plexus	
.....			

- *1 The clinical findings in TOS may be similar to those in carpal tunnel syndrome, ulnar neuropathy or cervical radiculopathy. A physician should consider these alternative diagnoses before requesting TOS surgery.
2. Most patients with TOS have cervical ribs.
 3. The Department of Labor and Industries has recently concluded a retrospective study of outcomes of thoracic outlet surgery on patients with Labor and Industries claims. The results indicate that long-term outcomes after TOS surgery are worse than outcomes with medical management of TOS.

SEE NEXT PAGE FOR DETAILS OF CRITERIA

Reference: Provider Bulletin 95-04; Date Introduced: April 1995

Criteria for the Electrodiagnostic Diagnosis of Unilateral Neurogenic Thoracic Outlet Syndrome (TOS)**

All 3 of the following criteria must be found in the affected limb:

1. Amplitude of median motor response is reduced
And
2. Amplitude of ulnar sensory response is reduced
And
3. Needle exam shows denervation in muscles innervated by lower trunk of brachial plexus.

Details Regarding the Above Noted Criteria:

Criterion #1

- a) Using standard surface electrodes with active pick up over the abductor pollicis brevis, the amplitude of the median motor response on the affected side should be less than 50% of that obtained on the unaffected side.

Criterion #2

- a) Using standard ring electrodes on the fifth digit, the ulnar sensory amplitude on the affected side should be less than 60% of the amplitude on the unaffected side.

Criterion #3

- a) Muscles innervated by the lower trunk of the brachial plexus include the abductor pollicis brevis, pronator quadratus, flexor pollicis longus, first dorsal interosseous, abductor digiti minimi, flexor carpi ulnaris, extensor pollicis brevis, and extensor indicis.
- b) EMG abnormalities in TOS are most commonly seen in median and ulnar innervated intrinsic muscles of the hand -- especially the abductor pollicis brevis.
- c) Positive waves and fibrillations may be found, but chronic denervation changes are more common -- that is, increased motor unit amplitude, increased motor unit duration, and decreased recruitment with rapid firing of motor units are activated.

Notes

The electromyographer should rule out neuropathic conditions that might mimic TOS, specifically cervical radiculopathy, carpal tunnel syndrome, ulnar neuropathy and polyneuropathy.

**Abstracted from Wilbourn A.J. American Association of Electromyography and Electrodiagnosis. Case Report #7: True Neurogenic Thoracic Outlet Syndrome. 1992.

Diagnoses and Treatment of Work-Related Carpal Tunnel Syndrome (OCTS)

These guidelines are to be used by physicians and Labor and Industries' claim managers.

SECTION 1 -- CLAIM ACCEPTANCE

In general, both appropriate symptoms and signs and work relatedness should be present for Labor and Industries to accept a claim as OCTS. Nerve conduction velocity testing (NCVs) is not necessary for claim acceptance except in questionable circumstances.

A. Symptoms and Signs

Appropriate symptoms would include, numbness, tingling or burning pain of one or both hands, especially noted after work and at night. These nocturnal symptoms are prominent in 50-70% of patients. Patients frequently awaken at night or early morning and shake their hands to rid themselves of these symptoms. The location of these symptoms may be in the entire hand or localized to the thumb and first two or three fingers. If the nerve symptoms are prominent only in the fourth and fifth fingers (ring and little fingers), a different diagnosis (e.g., ulnar neuropathy) should be considered. Although burning pain is often prominent in the hands and palm side of the wrists, an aching pain may radiate (be felt in) to the medial elbow region or more proximally to the shoulder.

Findings on physical examination (signs) are frequently absent or non-specific. Tinel's sign (tapping on the wrist or over the median nerve) and Phelan's signs (forced flexion of the wrist) are frequently described, but by themselves are not specifically diagnostic of OCTS. Their presence merely corroborates the presence of other clear neurologic symptoms.

Other signs are more specific and include decreased sensation to pin or light touch in the palm and first three digits or weakness or atrophy of the muscles of the thenar eminence (especially the abductor pollicis brevis). The presence of the latter signs (but not Tinel's or Phelan's) may suggest more acute or advanced nerve injury and perhaps the need for more aggressive treatment.

In general, symptoms are better when not working and on holidays when the worker has been removed from the workplace exposure. Non-specific symptoms, (e.g., pain without numbness, tingling or burning; "dropping things") should not be considered for the diagnosis of OCTS.

Reference: Provider Bulletin 95-10; Date Introduced: November 1995

Medical Treatment Guidelines

B. Work-relatedness

Any activity requiring extensive or continuous use of the hands in work may be an appropriate exposure. In general, one of the following work conditions should be occurring on a regular basis:

- 1) Repetitive hand use, especially for prolonged periods (e.g., keyboard users), against force (e.g., meat cutters) or with awkward hand positions (e.g., grocery checkers), with repeated wrist flexion, extension or deviation as well as forearm rotation, or with constant firm gripping.
- 2) The presence of regular, strong vibrations (e.g., jackhammer, chainsaw).
- 3) Regular or intermittent pressure on the wrist. (Note: acute carpal tunnel syndrome may be associated with acute trauma, i.e., fracture, crush injury of wrist, etc.).

The types of jobs that are most frequently mentioned in the literature or reported in L&I's data include: meat cutting; seafood, fruit, or meat processing or canning; carpentry; roofing; dry walling; boat building; book binding; wood products work; dental hygienist; and intensive word processing. This is not an exhaustive list. It is only meant to be a guide in consideration of work-relatedness. If the history of exposure is unclear, then speaking directly with the employer or claimant, or doing a walk through, to obtain more detailed information on job duties would be critical.

NERVE CONDUCTION TESTING (NCVs)

It is critical to obtain NCV testing in the following situations:

1. The attending physician's diagnosis is OCTS, but the clinical criteria (appropriate neurologic symptoms and/or signs) described above are not met.
2. The patient has been on time-loss for OCTS for more than two weeks and the clinical criteria are met.
3. Carpal tunnel decompression surgery is requested.

Conceptually, validation of the clinical diagnosis of OCTS depends on the finding of sequential slowing of sensory and/or motor fibers of the median nerve across the carpal tunnel.

The most useful nerve conduction tests with their **(upper limit of) normal cut-points** are as follows:

Median motor distal latency	4.5 msec (slowing would be longer, i.e., greater than 4.5 msec)
Median sensory distal latency	wrist-digit II (14 cm)=3.5 msec palm-wrist (8 cm)=2.2 msec
Median-ulnar sensory latency difference	finger-wrist difference (14 cm)=0.5 msec palm-wrist difference (8 cm) =0.3 msec

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These upper limit cut points are derived from published literature. If the electromyographer performs non-conventional tests for OCTS not listed here, normal values should have been established in that physician's laboratory.

Labs can use their own cut points if they have adequately established their own normal values.

In all cases, and particularly in cases with borderline NCV results, control for skin temperature should be documented. In general, the above referenced values will hold for skin temperature in the range of 30-34 degrees Centigrade. Lower temperatures will be associated with falsely slowed NCV results.

An electromyogram (EMG), or needle examination of the muscles supplied by the median nerve, may be useful in documenting actual nerve damage (axonal loss). This test should be done especially in cases with sensory loss, weakness or muscle atrophy in the median nerve distribution.

TREATMENT

A. Conservative treatment

Conservative management may be helpful and may include:

- 1) Splinting of the wrist. (May be more useful at night).
- 2) Anti-inflammatory medication including non-steroidal.
- 3) Steroid injections - although this form of treatment is favored by some physicians, it may not have long term benefits and may itself cause nerve injury. No more than ***two steroid injections over a three-month period*** will be authorized.

The duration of conservative treatment will primarily depend on whether the patient can remain at work. Most patients will improve when off work, whether or not specific treatment is rendered. In some cases, job modification, along with conservative treatment, may improve symptoms and prevent worsening of OCTS. If job modification is not possible, or if the claimant cannot continue working with conservative treatment, then surgery should be considered as a treatment option.

B. Surgery

Decompression of the transverse carpal ligament is the surgical procedure of choice for OCTS. A second procedure, internal neurolysis, or freeing up of the nerve, is sometimes requested; however, there is no evidence to suggest that this procedure is necessary and, in most cases, requests for this procedure will be denied.

Medical Treatment Guidelines

In general, the following criteria should have been met for authorization of surgery to occur:

1. The clinical history should be consistent with OCTS.
2. NCVs should have demonstrated a conduction slowing of the median motor or sensory fibers across the carpal tunnel.
3. A course of conservative management must have been tried.

Most studies suggest that in 60-90% of the post-surgical cases the burning pain associated with OCTS will be alleviated. The patient's ability to return to the same job is not clear. If pain persists or recurs, NCVs can help sort out whether nerve entrapment continues to be a problem.

SPECIAL CASES

Questions may arise in several specific situations that may raise questions about the validity of the claim for OCTS or about the need for surgery.

- A. Work-relatedness may not be obvious. Some work exposures do not meet the guidelines for work-relatedness. If there is a question about the job exposure and whether such exposure could cause OCTS, the claim manager should refer the case to the occupational medical consultant by calling (360) 902-5026.
- B. Surgery may be requested in those injured workers whose clinical picture and work relatedness is quite clear, but whose NCVs are normal. Most clinicians agree that a minority (<10%) of patients with clinical OCTS may have normal NCVs. Options here may be the following:
 1. Were the most sensitive and specific NCV tests done (e.g., palm-wrist median sensory latency)? If not, request that they be done.
 2. If the NCVs were done after a period of not working, previously abnormal NCVs may have returned to normal. It would be reasonable in these cases to suggest that the claimant return to work for a brief time (a few days to a week) and repeat NCVs while they are still working.
- C. If OCTS is not documented by clinical criteria and NCV testing, other clinical problems related to repetitive use (i.e., tendonitis) should be investigated and treated appropriately. It would also be important to rule out other neurologic causes of tingling in the hands. Referral to an appropriate specialist (neurologist, physiatrist) would be prudent in such cases.
- D. Carpal tunnel syndrome may also be caused by anything that decreases the cross-sectional area of the carpal tunnel or adds to the volume of the carpal tunnel, resulting in increased pressure on the median nerve. This could occur by distortion of the bones or ligaments by fracture or crush injury of the forearm or hand associated with generalized or chronic swelling (edema).

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- E. Carpal tunnel syndrome may be associated with other chronic conditions that may cause nerve damage or predispose a nerve to injury from compression. The most common of these conditions is diabetes. The key test here is whether, in spite of the presence of such condition, the symptoms of OCTS can be documented to have begun only after beginning work at the job in question.
- F. A predisposing, physiological condition is pregnancy, wherein increased plasma volume increases pressure within the carpal tunnel. In such cases, symptoms universally disappear immediately after birth. If they do not, other etiologies (e.g., work-related, diabetes) should be pursued.

RETURN TO WORK AFTER OCTS SURGERY

The vast majority of persons with work-related OCTS are expected to have dramatic relief of their symptoms after carpal tunnel decompression surgery and should return to their same job. Return to work, with or without job modification, should be tried in most people. If symptoms worsen or reappear after return to work, repeat NCVs will help to sort out if OCTS has recurred, and if surgery successfully removed the pressure on the median nerve (NCVs will improve with successful surgery, although they may not return completely to normal).

Medical Treatment Guidelines

Criteria for the Diagnosis and Treatment of Work-Related Carpal Tunnel Syndrome				
PROCEDURE	CONSERVATIVE CARE	Clinical Findings		
		SUBJECTIVE	OBJECTIVE	DIAGNOSTIC
<p>DECOMPRESSION OF THE MEDIAN NERVE</p>	<ul style="list-style-type: none"> - Splinting - Anti-inflammatory medication - Steroid injections* <p>* No more than 2 injections in 3 months</p> <p>NOTE: In the absence of conservative care or with minimal conservative care, a request for surgery can still be considered pending clinical findings.</p>	<p style="text-align: center;">AND</p> <ul style="list-style-type: none"> - Complaints of numbness, tingling or "burning" pain of the hand or thumb and first 2 fingers. <p>Nocturnal symptoms may be prominent</p> <p>NOTE: Pain may radiate to inner elbow or to the shoulder</p>	<p style="text-align: center;">OR</p> <ul style="list-style-type: none"> - Decreased sensation to pin in palm and first 3 digits <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> - Weakness or atrophy of the thenar eminence muscles. 	<p style="text-align: center;">AND</p> <ul style="list-style-type: none"> - Abnormal nerve conduction studies. Any one abnormality in one of the following*. - Median motor distal latency >4.5 msec - Median sensory distal latency wrist digit II (14 cm) >3.5 msec - palm-wrist (8 cm) >2.2 msec - Median-ulnar sensory latency finger-wrist difference >0.5 msec - palm-wrist difference >0.3 msec <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> - Positive Needle EMG in cases of definite sensory deficit in median nerve distribution or weakness/atrophy of the thenar muscle <p>NOTE: If test result borderline, may want to repeat after (attempts to) RTW.</p> <p>*NCV must be done with control for skin temperature. Values are true for temperature in range of 30-34 C.</p>
	<p>Nerve conduction studies should be done if worker is off work for > than two weeks or surgery requested.</p>			

Medical Treatment Guidelines

SECTION 2 -- NEEDLE ELECTROMYOGRAPHY IN THE DIAGNOSIS OF CARPAL TUNNEL SYNDROME

Needle electromyography has only a limited role in the electrodiagnostic evaluation of carpal tunnel syndrome. It should generally not be done if nerve conduction studies are normal. There are three circumstances in which it would be reasonable to do needle electromyography during an evaluation for carpal tunnel syndrome:

- a. Nerve conduction studies are abnormal in a manner indicating carpal tunnel syndrome, and the patient demonstrates wasting or clinical weakness of the thenar muscles.
- b. The electromyographer suspects that a neuropathic process other than (or in addition to) carpal tunnel syndrome exists (e.g., diabetes).
- c. There is a history of an acute crush injury or other major trauma to the distal upper extremity.

Medical Treatment Guidelines

SECTION 3 -- WORKSHEET FOR CARPAL TUNNEL SYNDROME ELECTRODIAGNOSTIC STUDIES

DOCTORS PLEASE NOTE: This worksheet should accompany, BUT NOT REPLACE, the detailed report normally submitted to the department.

1. The purpose of this worksheet is to help medical consultants at L&I interpret electrodiagnostic testing that you do on L&I patients. It is for this reason that the worksheet follows on distal latency. The worksheet should be used only when the main purpose of your study is to evaluate a patient for OCTS.
2. You may have an automated system for reporting electrodiagnostic results. Feel free to send this in. But the department's worksheet should also be filled out and submitted.
3. On the worksheet, sensory distal latency should be measured to response peak and motor distal latency should be measured to response onset.
4. It is not necessary to do all the conduction studies listed on the worksheet. You should do only the studies needed to rule OCTS in or out.
5. It is sometimes necessary to do electrodiagnostic tests other than ones listed on the worksheet. If you do any additional studies bearing on the diagnosis of OCTS, please write them in the blank area below the listed studies.
6. If the inching technique of Kimura is used, only a maximum latency difference between 1 cm segments of 0.5 msec will be accepted as specific enough to corroborate the presence of OCTS.
7. The value of other studies of median nerve function has not been proven. These tests are NOT recommended for the diagnosis of OCTS. The following quotation is taken from a literature review published in *Muscle & Nerve*, 1993, Vol. 16, p. 1392-1414:

“Several other variations on median sensory and motor NCS's have been reported to be useful for the evaluation of patients with OCTS. The committee's review of the literature indicated that the value of these tests for the clinical electrodiagnostic evaluation of patients with OCTS remains to be established. These electrodiagnostic studies include the following: (1) studies of the median motor distal latency recorded from the lumbrical muscles,.. (2) measurement of the refractory period of the median nerve,.. (3) median motor residual latency measurements,.. (4) terminal latency ratio,.. (5) median F-wave abnormalities,.. (6) median motor nerve conduction amplitude comparisons with stimulation above and below the carpal ligament,.. (7) anterior interosseous/median nerve latency ratio,.. (8) change in median motor response configuration with median nerve stimulation at the wrist and elbow in the presence of Martin-Gruber anastomosis,.. (9) sensory amplitude measurements,.. and (10) measurement of median sensory and motor nerve conduction across the wrist before and after prolonged wrist flexion.”

The Washington State Medical Association (WSMA) Medical Treatment Guidelines Subcommittee and the Department of Labor and Industries Office of the Medical Director endorses the opinions in the above quote and believe that electromyographers should act in accordance with these opinions.

Medical Treatment Guidelines

Worksheet for Carpal Tunnel Nerve Conduction Studies

	Abnormal cut-point	Right Arm Distal Latency (msec)	Left Arm Distal Latency (msec)
1. Median motor to APB	>4.5 msec		
2. Median sensory over 14 cm (wrist to digit 2 or 3)	>3.5 msec		
3. Median sensory over 8 cm (transcarpal)	>2.2 msec		
4. Median sensory to Digit 4 MINUS Ulnar sensory to Digit 4	>.5 msec		
5. Median sensory (transcarpal) MINUS Ulnar sensory (transcarpal)	>.3 msec		
6. Ulnar sensory to Digit 5	>3.6 msec		

Claim Number: _____

Claimant Name: _____

Additional Comments:

Signed

Date

Medical Treatment Guidelines

Psychiatric Conditions

Treatment may be authorized for psychiatric conditions caused or aggravated by an industrial condition. Treatment may also be temporarily authorized for unrelated psychiatric conditions that are retarding recovery of an allowed industrial condition. **However, unrelated conditions are NOT the responsibility of the department.** The department will stop payment for temporary treatment of unrelated conditions when:

- The allowed industrial condition is resolved, or
- The allowed industrial condition is no longer delayed from recovery by the unrelated psychiatric condition(s).

Psychiatric treatment must be provided in an “intensive” manner, which the department defines as at least 10-12 treatments in a 90-day authorization period. Prior authorization is required for **both** an initial psychiatric evaluation and for continued treatment.

A psychiatrist or a licensed psychologist must provide all psychiatric treatment. A psychiatrist may certify time loss compensation if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability. A psychologist may not certify time loss compensation, sign the Report of Accident, act as the attending physician, or rate permanent partial disability.

The psychiatrist or psychologist must submit a goal-directed treatment plan and reports that contain a summary of subjective complaints, objective observations, assessment toward meeting measurable goals, an updated intensive goal-directed treatment plan, and include the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV or current edition) axis format assessment.

Doctors treating psychiatric conditions allowed on a claim need to submit progress reports to the claim manager every sixty days (WAC 296-21-270). If temporary treatment has been authorized for an unrelated psychiatric condition, progress reports need to be submitted to the claim manager every thirty days (WAC 296-20-055).

Purpose of the Guideline

This guideline will assist psychologists and psychiatrists who treat injured workers for psychiatric conditions that are either the direct result of an industrial injury or are unrelated but retarding recovery from an industrial injury. This guideline may also be useful to physicians who treat injured workers’ physical conditions, but who from time to time refer injured workers to psychiatrists or psychologists for treatment of psychiatric conditions. The guideline’s usefulness in each of these settings is in part because the documentation described in the guideline will allow claim managers to validate their decisions, and thus helps to ensure efficient medical management of the claim.

Reference: Provider Bulletin 03-03; Date Introduced: March 2003

Medical Treatment Guidelines

The presence of pre-existing psychiatric conditions may delay or prevent recovery from industrial injuries. In many instances, treatment of such conditions is NOT the responsibility of the department and self-insurer or self-insured employer. However, to assist an employee in recovering from an industrial injury or disease, the department or self-insured employer may elect to pay for some level of treatment of such a condition, until the accepted claim condition is “fixed and stable”, i.e., reached maximum medical improvement, or no longer delayed from recovery by the unrelated condition.

Insurance companies often distinguish between industrial injuries and occupational diseases. Though the distinction can have substantial consequences in any given claim, for simplicity this guideline will use the term “industrial injury” to refer to both industrial injuries and occupational diseases.

Authorization Requirements

Initial psychiatric evaluation and ongoing treatment of a psychiatric condition both require prior approval from the department or self-insured employer (WAC 296-21-270). Authorization for psychiatric treatment may be granted for periods of 90 days or less. Subsequent authorization periods of 90 days or less are contingent on documented progress in psychiatric treatment.

Claim managers may authorize payment for treatment of psychiatric conditions that are retarding recovery from an industrial injury, even though the injury did not cause the psychiatric condition, or aggravate a pre-existing psychiatric condition. Claim managers can also authorize payment for treatment of psychiatric conditions when they have been caused or aggravated by an industrial injury.

If authorization for psychiatric treatment is requested following an initial psychiatric evaluation, the claim manager will make a determination as to the relationship between the industrial injury and the psychiatric condition based on the information provided. For this reason, it is very important for the psychiatrist or psychologist to clearly indicate their opinion, and the basis for their opinion, whether:

- The injured worker’s psychiatric condition was not caused or aggravated by the industrial injury, but it creates a barrier to recovery from a condition for which the department has accepted liability.
- The injured worker’s psychiatric condition was caused by the industrial injury.
- The injured worker’s psychiatric condition is a pre-existing condition that was aggravated by the industrial injury.
- The injured worker’s psychiatric condition was neither caused nor aggravated by the industrial injury, nor is it creating a barrier to recovery from a condition for which the department has accepted liability.

Elements of a Comprehensive Psychiatric Plan

Elements of a comprehensive psychiatric treatment plan would include formulation of a psychiatric diagnosis; identification of barriers to recovery; development of an intensive, goal-directed plan; and recommendation for duration of therapy.

Diagnosis of a Psychiatric Condition

Diagnosis is an essential first step to the development of a plan for treatment of psychiatric conditions. Diagnoses should be specific, and should use the nomenclature and numerical identification of the DSM-IV (or current edition). The diagnostic section of the initial report, and all subsequent reports, should address all five axes described in the DSM-IV (or current edition). Diagnoses should be based on all relevant historical information. Specific inquiry should be made into the patients' pre-injury and current medical, psychosocial, and psychological status. Whenever possible, prior medical records should be reviewed to screen for the presence of diagnostically important information, and for information that may be useful in the creation of a treatment plan. Carefully document any pertinent positive or negative historical information.

Consideration should be given to the use of standardized measuring tools, such as the Rollins® or Beck® scales, and the use of individualized visual analog scales. Such measurements provide both support for diagnoses and benchmarks against which progress in treatment can be measured.

Identification of Barriers to Recovery from an Industrial Injury

Each diagnosed psychiatric condition should be assessed to determine whether it is retarding a patient's recovery from an industrial injury. Any such barriers should be clearly identified and the report should provide an explanation that links the psychiatric condition to an observable, measurable behavior that interferes with recovery from an industrial injury.

Example: Diagnosis: Depression, Major, Single episode (296.2)
 Barriers created by condition:

1. Insomnia: Patient is only able to sleep 2- 3 hours at a time and his sleep is fitful;
2. Fatigue: Patient has no energy, and feels too tired to participate in reconditioning program;
3. Despondency: Patient does not believe he will ever again be able to return to productive employment;
4. Maladaptive personality trait expression: Patient expresses anger towards employer, which is exacerbated by chronic lack of sleep, fatigue and despondency.

Specific inquiry should be made to determine whether there are employment-related risk factors that should be addressed in a health care setting. For example, anger towards the employer, supervisor or coworkers may need to be addressed. Economic disincentives and employment-related loss of self-esteem can each contribute to the failure of a worker to make expected progress in recovery. Feelings of victimization may delay a return to a normal lifestyle. Such risk factors should be carefully identified and documented. Additional risk factors are discussed in the Attending Doctor's Handbook; "Helping Patients Return to Work", in the "Screening Checklist for Possible Risk Factors". Additional copies of the Attending Doctor's Handbook are available without charge from the Department of Labor and Industries.

Medical Treatment Guidelines

Formulation of a Psychiatric Treatment Plan

The psychiatrist or psychologist evaluating a worker with a psychiatric condition should create a treatment plan that addresses each diagnosed psychiatric condition and any identified barriers to recovery. The treatment plan must include intensive, goal-directed treatment and include a recommended duration of treatment. The treatment plan should be included in the evaluation report and updated throughout treatment.

Objectively determinable measurements of recovery should be identified for each condition for which treatment is proposed. Objective measurements should be individualized so that each patient's progress or lack of progress will be accurately assessed. Examples of such measurements include documentation of the level of physical activity; improved participation in physical therapy, occupational therapy, work hardening, or vocational counseling programs; normalization of common behavior patterns such as sleep cycles and eating disorders; and changes in medication usage. To the extent that a treatment plan may recommend medications, the plan should include a discussion of any predictable drug interactions the recommended medications might have with medications the worker is currently taking.

Example: Diagnosis: Depression, Major, Single episode (296.2)
 Plan: 1. Intensive Psychotherapy: Weekly for 12 weeks;
 2. Antidepressants: Sinequan® 50mg qhs, then increase as
 needed. No anticipated interaction with patient's current regimen
 of Motrin® and acetaminophen.

Identification of the measured variable should include a description of what will be measured, the intervals and duration during which the variable will be measured, the anticipated endpoint, and the anticipated progress to that endpoint at each interval measurement. When appropriate, use standardized measurements such as the Rollins® or Beck® scales to document the extent of recovery. Each variable to be measured should be explained to the injured worker before treatment is actually commenced. If necessary, the patient should be instructed in how to complete diaries that document such variables as pain, activity, medication use, etc.

In the event that the psychiatric treatment plan includes measurements of indicators that are outside the practice of the psychiatrist or psychologist, prior arrangements to obtain such measurements should be made by the psychiatrist or psychologist with the attending doctor. Such measurements should be available to the psychiatrist or psychologist at the time each respective progress note is created.

Example: Measurements arranged by the psychiatrist or psychologist and the attending doctor

The psychiatrist evaluating a knee injury patient includes monthly measurements of flexion and extension of the knee as two of the objective determinants of whether treatment is lowering barriers to the patient's recovery from a knee injury. The psychiatrist does not measure such parameters as part of his/her practice. At the time the psychiatrist creates the treatment plan, a check should be made with the attending physician to determine whether that doctor can make monthly assessments of flexion and extension of the knee. Copies of the measurement results should be available to the psychiatrist or psychologist by the 15th of each of the next three months, for review when the injured worker is seen next.

Medical Treatment Guidelines

Arrangements may be made with a physical therapist to provide such measurements. The psychiatrist summarizes the arrangement in the treatment plan.

Assessment of Psychiatric Treatment and Recommendations

A progress note should be prepared following each clinic visit. Per WAC 296-20-06101, legible copies of progress notes must be submitted to the department for all treatment. The progress note should document the patient's interval history, and should summarize any pertinent positive or negative findings. Indicators that are measured to assess progress should be documented along with measurements obtained during the interval period. An assessment should be made as to whether the measurements reflect the expected progress.

A visual analog scale can be a useful tool in assessing a patient's perception. Generally, such scales consist of a 10 cm horizontal line with words at opposite ends of the spectrum. Studies have shown that visual analog scales are most accurately representative of that which they seek to measure when the horizontal line contains no arbitrary divisions such as numbers, interval marks, etc. The patient is instructed to place a vertical mark at the point on the line that seems most appropriate to the patient.

Should expected progress not be made, the report of the psychiatrist or psychologist should contain a discussion concerning the postulated reasons for lack of progress. If necessary, the treatment plan should be reassessed, and any necessary modifications made.

The following is an example of a progress note that includes the goal-directed treatment plan along with an assessment of the injured worker's functioning. It is not necessary to include the goal-directed treatment plan in each progress report unless there have been changes in the treatment plan.

Example: Diagnosis: Depression, Major, single episode (296.2)

Measurements:

1. Physical Activity

- a. Goal: Within 60 day's patient will have returned to his pre-injury level of activity.
- b. Measurement: Patient will log hours of sleep and daily activities.
- c. Interval: Patient will complete log daily; logs will be reviewed weekly.
- d. Mileposts: Week 1: Patient will sleep no more than 10 hours a day by the end of the week, and will document twenty minutes of activity, daily, by the end of the week. Week 2: Patient will sleep no more than 9 hours a day by the end of the week, and will have increased daily exercise to 30 minutes per day. Weeks 3 through 8: Sleep will not exceed 8 hours per day; patient will exercise at least 1 hour daily.

2. Communication

- a. Goal: Decrease or eliminate anger-related return to work barriers.
- b. Measurement: Patient response to scenarios that currently cause patient to become angry and poorly communicative.
- c. Interval: Will be assessed at each counseling session.
- d. Mileposts: By week 4, patient will be able to verbalize the reasons for his anger. By week 8, patient will be able to remain appropriately communicative in employment situations that currently evoke angry outbursts.

Medical Treatment Guidelines

3. Return to Work

- a. Goal: Within 90 days patient will return to work full time.
- b. Measurement: Patient completes gradual return to work plan.
- c. Interval: Patient's progress will be assessed monthly.
- d. Mileposts: Month 1: By the end of the first month of treatment, patient will have returned to work part time 4 hours a day with restricted duties. Month 2: By the end of the second month of treatment, patient will have returned to work part time 6 hours a day and assumed normal duties. Month 3: By the end of the third month of treatment, patient will have return to work full time.

Assessment

Since the last visit, patient has returned to light duty 4 hours a day. He reports an improvement in sleep with the increase in the dose of his antidepressant; he now feels rested after 8 hours of sleep. He is now exercising one hour a day, and is participating in household activities such as cutting the lawn with a power mower. He reports that on weekends he and his wife walk their dog for about one hour each day. Patient has met the physical activity and vocational rehabilitation goals for this period.

What are the Reporting Requirements?

All reports should be written in a legible style that can be understood by non-medical personnel. Each report must contain at least a summary of subjective complaints, objective observations, assessment of progress toward meeting goals, updated treatment plan, and DSM-IV (or current edition) axis format assessment (WAC 296-21-270). The use of specific examples of a patient's behavior may be a helpful way to communicate the effects of a psychological condition, or the effects of treatment for such a condition.

Doctors treating psychiatric conditions allowed on a claim are required to submit progress reports to the claim manager every sixty days (WAC 296-21-270). If temporary treatment has been authorized for an unrelated psychiatric condition, progress reports are required to be submitted to the claim manager every thirty days (WAC 296-20-055).

What are the Billing Codes?

Complete information on billing codes may be found in the Medical Aid Rules and Fee Schedules, Professional Services, Psychiatric Services section, Appendix H, or <http://www.lni.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/fsAMAgree.asp>.

Collaborative Guidelines on the Diagnosis of Porphyria and Related Conditions

Prepared By

**The Washington State Department of Labor and Industries
And
The Washington State Medical Association's
Committee on Industrial Insurance and Rehabilitation**

October 18, 1995

Purpose and Development of these Guidelines

The purpose of these guidelines is to provide information for treating physicians and independent medical examiners to use in evaluating patients with possible exposure-related porphyria, and to provide a foundation for developing Department medical policy.

The focus of these guidelines is on the phase of the medical evaluation where a decision must be made whether to proceed with an extensive work-up to reach a definitive diagnosis, or to conclude that results of a preliminary evaluation make a diagnosis of porphyria unlikely (see Section III). It is beyond the scope of these guidelines to provide detailed algorithms for reaching a conclusive diagnosis.

These guidelines were developed with the input and approval of numerous nationally and internationally recognized experts on porphyria. Input was also incorporated from many other individuals, including physicians representing a wide variety of specialties and non-physicians with an interest in this topic.

The scientific basis for these guidelines, along with additional information about their development, can be found in a review document on porphyria prepared by the Office of the Medical Director of the Washington State Department of Labor and Industries. These guidelines may be revised as new scientific information becomes available.

Date Introduced: October 1995

Medical Treatment Guidelines

General Information

Porphyrias are metabolic disorders in which the clinical manifestations are attributable to decreased activity of a specific enzyme(s) in the heme synthesis pathway, associated with characteristic patterns of overproduction of specific heme precursors and resultant accumulation in certain tissues. Each enzyme deficiency results in a predictable accumulation of the preceding heme precursor(s), and overall production of heme is generally preserved. Porphyrias, when clinically active, and in some cases even when latent or in clinical remission, are characterized by high levels of heme precursors in blood, urine, and/or stool. Most types of porphyria are inherited conditions; however, one type of porphyria, porphyria cutanea tarda, is known to occur in acquired or inherited manner.

Many of the tests used to diagnose the porphyrias are nonspecific and are abnormal in many circumstances other than the porphyrias. Porphyrinuria, i.e., increased urine porphyrins, can be caused by porphyrias, by a number of other medical conditions, and by a variety of exogenous factors such as alcohol and certain drugs and chemicals that disturb heme synthesis or stress heme-dependent metabolism. The term "secondary porphyrinuria" is commonly used in reference to the porphyrinuria occurring with conditions and factors lacking a primary enzyme defect in heme synthesis. It usually involves mild or moderate coproporphyrinuria, with no or little excess uroporphyrin in urine, and is also often called "coproporphyrinuria" or "secondary coproporphyrinuria."

In individuals who are genetically predisposed to developing an acute or cutaneous porphyria, manifestations of porphyria can be *triggered* by a variety of exogenous factors including alcohol, certain therapeutic drugs and chemicals, infections, dietary factors and sun exposure, as well as by certain medical conditions and endogenous factors such as menstruation and administered steroid hormones. Exogenous factors can also *cause* changes in the heme synthesis pathway, even in the absence of genetic predisposition; in some cases, these acquired changes have been reported to cause porphyria cutanea tarda.

Lead absorption, both acute and chronic, is well documented to affect heme synthesis. Lead causes accumulation of protoporphyrin in erythrocytes and large increases of ALA and coproporphyrin in urine. Lead inhibits ALA dehydratase, and also appears to interfere with the function of two other heme synthesis enzymes. Lead intoxication is generally classified as a secondary porphyrinuria rather than as an acquired porphyria, although it does have clinical and biochemical similarities with acute porphyrias.

A number of chemicals, primarily halogenated hydrocarbons and metals, are known to be "porphyrogenic" (i.e., capable of inducing changes in heme synthesis, with subsequent overproduction and excessive excretion of heme precursors) in experimental animals, generally with doses much greater than the range of human experience. In humans, with the noteworthy exceptions of porphyria caused by hexachlorobenzene and the "porphyrinuria" caused by lead, reports of porphyria or porphyrinuria attributable to chemical exposures have been infrequent. It must be acknowledged, however, that there has been only limited systematic study of the subject in humans. The reported findings have generally been linked to chronic industrial exposures, industrial accidents, or environmental exposures that were much higher than normally encountered.

Medical Treatment Guidelines

Diagnosis

The most important first step toward diagnosing or ruling out porphyria in a symptomatic patient is for the physician to maintain a high index of suspicion for a possible diagnosis of porphyria, whether symptoms are "classic" for a porphyria or are vague or unexplained. The conclusive diagnosis of a porphyria should be based on a systematic approach incorporating medical history, physical examination, and biochemical data, including genetic evaluation if necessary. Certain symptom patterns, physical findings, and elements of the exposure history may raise the degree of suspicion for porphyria; however, the lack of supporting information from these sources cannot exclude a diagnosis of porphyria. Therefore, the systematic approach to evaluating a symptomatic patient with suspected porphyria should begin with laboratory evaluation.

In a person with symptoms from a porphyria, the level of the most excessively excreted heme precursor is typically at least several-fold greater than the upper limit of values found in normal individuals.

A. Minimum ("Threshold") Criteria

Physicians must sometimes decide whether an extensive work-up for porphyria is indicated. In order to assist clinicians in this decision, the following threshold criteria are recommended:

In a patient who is currently or recently symptomatic and who is suspected to have a porphyria, it is not probable that the patient's symptoms are attributable to a porphyria of any type unless a measurement on at least one of the following tests is greater than twice the upper limit of normal:

- **urine porphobilinogen (PBG)**
- **urine uroporphyrin**
- **fecal coproporphyrin**
- **blood total porphyrins**
- **urine coproporphyrin**

B. Caveats

- 1. Reference range:** Because a reference range may be unique to the assay method and the individual laboratory performing the test, test results should be interpreted relative to the laboratory-specific reference range and/or, if sufficient general clinical experience exists, against accepted absolute reference standards.
- 2. Blood Lead Level:** A blood lead level should be checked to determine the possibility of lead intoxication if lead exposure is suspected, if excretion of coproporphyrin or ALA is increased, or if blood porphyrins (e.g., blood zinc protoporphyrin [ZPP]) are increased.
- 3. Repeat testing and factors affecting test results:** Laboratory test results, in general, can be compromised by a variety of factors including specimen integrity, analytical quality, limitations of analytical methods, and the applicability and specificity of reference ranges or "control" data. Issues of specimen integrity may be particularly relevant when specimens are collected and processed at one site, and then transported to a geographically distant reference laboratory.

Medical Treatment Guidelines

Because of these risks, an abnormal test result generally should be confirmed by analysis of a second specimen before the test result is used to finalize a diagnostic conclusion. The need to repeat a test, of course, must be tempered by the degree of support for a diagnosis from other clinical and laboratory data, and by the feasibility of repeating the test (i.e., the appropriate clinical circumstances should still be present).

4. **Enzyme measurements:** If a person is currently or recently symptomatic and is found to have reduced activity of a specific heme synthesis enzyme, but laboratory testing does not also reveal overproduction and excessive excretion of heme precursors in a pattern and levels consistent with the porphyria specific to that enzyme, then the reduction in measured enzyme activity has no probable causative relationship to the person's symptoms.
5. **Additional testing:** Satisfaction of these "twice the upper limit of normal" criteria *does not necessarily establish* a diagnosis of porphyria. Depending on the degree and pattern of abnormalities on these tests, additional testing may be necessary to establish or exclude a diagnosis of porphyria. It is possible that an individual could have an abnormal heme precursor measurement with this degree of abnormality (i.e., twice upper normal) as a consequence of something other than porphyria (or lead intoxication). Other medical conditions can cause "secondary" porphyrinuria of this magnitude. Blood porphyrins can also be increased by this magnitude in conditions other than porphyria: for example, iron deficiency commonly produces an increase in blood zinc protoporphyrin (ZPP).
6. **Timing of specimen collection:** Conversely, failure to satisfy these "twice the upper limit of normal" criteria *does not necessarily exclude* a diagnosis of porphyria. Heme precursor measurements in the range of one to two times the upper normal value should not be interpreted as "normal," but rather as *indeterminate or non-diagnostic*. When a patient with suspected porphyria is not currently or recently symptomatic, the levels of heme precursor excretion are generally lower and can even normalize with time. If a patient's last symptoms occurred remotely in time relative to specimen collection, it may be necessary to repeat the tests during or as soon as possible after future symptoms.
7. **"Secondary porphyrinuria":** Porphyrinuria sometimes secondarily reflects the presence of a medical condition or exogenous factor that disturbs heme synthesis or stresses heme-dependent metabolism but produces symptoms through a separate mechanism. With the noteworthy exception of lead poisoning, the porphyrin excess in "secondary porphyrinuria" has no recognized, clinically detectable consequences of its own; symptoms associated with secondary porphyrinuria (other than lead poisoning) are attributed by most experts to the condition or agent causing the porphyrinuria, or to an unrelated cause, and not to a disturbance in heme synthesis. Although the porphyrinuria itself may be benign, the associated medical condition may be far from benign.

Medical conditions that appear to have only secondary effects on the heme synthesis pathway are appropriately evaluated with attention focused on the primary condition. Similarly, when chemical exposures are suspected as the cause of a patient's symptoms or medical condition, the exposure relationship can be characterized more specifically by assessment of the exposure situation or by quantification of the suspected chemical (or its metabolite) in blood or urine, than by measurement of heme precursors.

Complex Regional Pain Syndrome (CRPS)

Formerly known as Reflex Sympathetic Dystrophy

1. INTRODUCTION

This bulletin outlines the Department of Labor and Industries' guidelines for diagnosing and treating Complex Regional Pain Syndrome (CRPS) – formerly known as Reflex Sympathetic Dystrophy (RSD). This guideline was developed through collaboration between the Washington State Medical Association (WSMA) Industrial Insurance/Rehabilitation Committee and the Office of the Medical Director of the Department of Labor and Industries. The protocol for CRPS physical therapy/occupational therapy (see Table 2) was developed in collaboration with the Washington State Physical Therapy and Occupational Therapy Associations.

2. WHAT IS COMPLEX REGIONAL PAIN SYNDROME?

Complex Regional Pain Syndromes are painful conditions that usually affect the distal part of an upper or lower extremity and are associated with characteristic clinical phenomena as described in [Table 1](#). There are two subtypes – CRPS Type I and CRPS Type II.

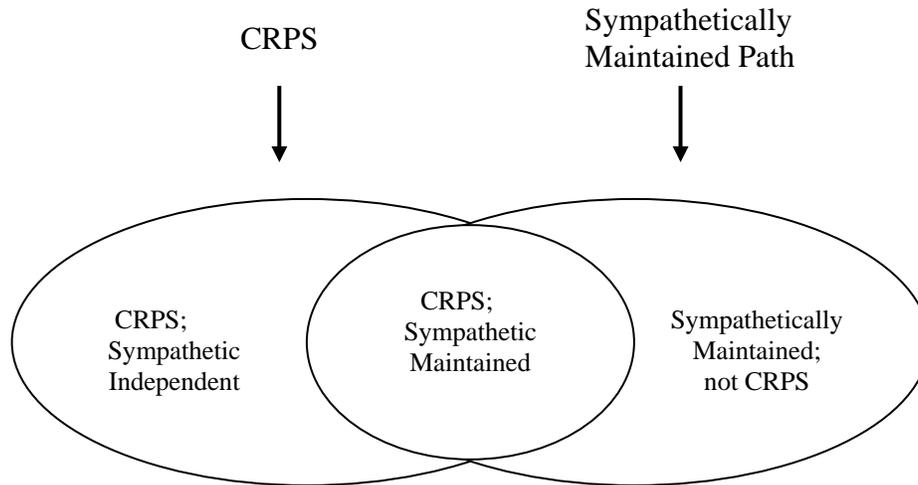
The term “Complex Regional Pain Syndrome” was introduced to replace the terms “reflex sympathetic dystrophy.” CRPS Type I used to be called reflex sympathetic dystrophy. CRPS Type II used to be called causalgia. The terminology was changed because the pathophysiology of CRPS is not known with certainty. It was determined that a descriptive term such as CRPS was preferable to “reflex sympathetic dystrophy” which carries with it the assumption that the sympathetic nervous system is important in the pathophysiology of the painful condition.

The terms CRPS Type I and CRPS Type II are meant as descriptors of certain chronic pain syndromes. They do not embody any assumptions about pathophysiology. For the most part the clinical phenomena characteristics of CRPS Type I are the same as seen in CRPS Type II. The central difference between Type I and Type II is that, by definition, Type II occurs following a known peripheral nerve injury, whereas Type I occurs in the absence of any known nerve injury.

Reference: Provider Bulletin 97-05; Date Introduced: June 1997

Medical Treatment Guidelines

Pain that can be abolished or greatly reduced by sympathetic blockade (for example, a stellate ganglion block) is called sympathetically maintained pain. Pain that is not affected by sympathetic blockade is called sympathetically independent pain. The pain in some CRPS patients is sympathetically maintained; in others, the pain is sympathetically independent. The relation between CRPS and sympathetically maintained pain can be seen in the following Venn diagram:



*******PHYSICIANS PLEASE NOTE*******

If you believe the CRPS condition is related to an accepted occupational injury, please provide written documentation of the relationship (on a more probable than not basis) to the original condition. Treatment for CRPS will only be authorized if the relationship to an accepted injury is established.

3. DIAGNOSTIC CODES

After treatment authorization has been obtained from the claim manager, physicians should use billing codes that are designated for reflex sympathetic dystrophy in the International Classification of Diseases (ICD-9CM) to bill. The relevant code numbers are described below:

ICD 9-CM Code	English Description
337.20	Reflex sympathetic dystrophy, unspecified
337.21	Reflex sympathetic dystrophy of the upper limb
337.22	Reflex sympathetic dystrophy of the lower limb
337.29	Reflex sympathetic dystrophy of other specified site

Medical Treatment Guidelines

4. KEY ISSUES IN MAKING A DIAGNOSIS

A. CRPS is a Syndrome – See whether your patient’s symptoms and signs match those described in [Table 1](#).

B. CRPS is Uncommon - Most patients with widespread pain in an extremity do **NOT** have CRPS. **Avoid the mistake of diagnosing CRPS primarily because a patient has widespread extremity pain that does not fit an obvious anatomic pattern.** In many instances, there is no diagnostic label that adequately describes the patient’s clinical findings. It is often more appropriate to describe a patient as having “regional pain of undetermined origin” than to diagnose CRPS.

C. Is CRPS a Disease? – Many clinicians believe that CRPS can best be construed as a “reaction pattern” to injury or to excessive activity restrictions (including immobilization) following injury. From this perspective, CRPS may be a complication of an injury or be iatrogenically induced but it is not an independent disease process.

D. Type I CRPS vs. Type II CRPS – In a patient with clinical findings of CRPS, the distinction between Type I and Type II CRPS depends on the physician’s assessment of the nature of the injury underlying the CRPS. In many situations, the distinction is obvious – if CRPS onsets following an ankle sprain or a fracture of the hand, it is Type I CRPS. If CRPS onsets following a gunshot wound that severely injures the median nerve, it is Type II CRPS. In ambiguous situations (for example CRPS in the context of a possible lumbar radiculopathy), the physician should be conservative in diagnosing Type II CRPS. This diagnosis should be made only when there is a known nerve injury with definable loss of sensory and/or motor function.

5. TYPICAL CLINICAL FINDINGS

A diagnostic algorithm that details the following clinical findings is located in [Table I](#) at the end of this guideline.

A. History

1. Symptoms develop following injury (usually symptoms begin within 2 months post injury).
2. Onset is in a single extremity
3. Burning pain
4. Hyperalgesia or allodynia (allodynia means pain elicited by stimuli that normally are not painful, i.e., a patient reports severe pain in response to gentle stroking of the skin.)
5. Swelling
6. Asymmetry or instability of temperature or color
7. Asymmetry or instability of sweating
8. Trophic changes of skin, nails, hair

B. Findings by Examination

1. Hyperalgesia or allodynia
2. Edema (if unilateral and other causes excluded)
3. Vasomotor changes such as asymmetry or instability of temperature/color
4. Sudomotor changes such as excess perspiration in affected extremity

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5. Trophic changes such as shiny skin, hair loss, abnormal nail growth
6. Findings suggestive of impaired motor function such as:
 - (a) tremor
 - (b) abnormal limb positioning
 - (c) diffuse weakness that cannot be explained by neuralgic loss or by dysfunction of joints, ligaments, tendons or muscles.

C. Diagnostic Test Results

A three-phase bone scan with characteristic pattern of abnormality. (NOTE – An abnormal bone scan is **not** required for the diagnosis of CRPS.)

D. Lack of Reasonable Alternative

No other anatomic, physiologic or psychological condition that would reasonably account for the patient's pain and dysfunction.

6. SYMPATHETIC BLOCKADE IN THE DIAGNOSIS OF CRPS

- A.** CRPS is considered a clinical syndrome, based on the criteria previously described in typical clinical findings and detailed in Table 1.
- B.** A patient's response to a diagnostic sympathetic block provides information about whether his/her pain is sympathetically maintained, but neither establishes nor refutes a diagnosis of CRPS. Therefore, a sympathetic block is not considered to be a definitive diagnostic test for CRPS.
- C.** In the patient with CRPS the purpose of a sympathetic block is to guide treatment. If a CRPS patient responds positively to a sympathetic block (indicating that his/her pain is sympathetically maintained) repeat blocks might be useful in the overall treatment plan.
- D.** If a patient does NOT meet the criteria for diagnosing CRPS as given in Table I, but the attending physician feels that the patient has sympathetically maintained pain, you may request authorization for a diagnostic sympathetic block. Requests to the state fund for a diagnostic sympathetic block should be sent to the L&I Office of the Medical Director for review.

7. AN OVERVIEW OF TREATMENT

Experts in CRPS believe the probability of a patient developing this condition can be reduced by early mobilization/activation following injury or surgery.

Conversely, unnecessarily prolonged immobilization following injury or surgery may set the stage of iatrogenic CRPS. Therapy for CRPS should be directed toward the goals of physical restoration and pain control. Details regarding treatment are presented in Tables 1 and 2 located at the end of this Guideline.

A. Physical Restoration

Experts agree that CRPS patients usually become trapped in a vicious cycle in which guarding and activity restrictions perpetuate the pain of CRPS. Therapy for CRPS should be directed toward breaking the pain cycle by having patients participate in a progressive activation program for the affected limb.

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1. Because patients usually resist using the affected extremity, the physical restoration program generally requires supervision by a physical therapist or occupational therapist.
2. Involvement of a physical or occupational therapist is important so that repeated measurements of a patient's functional capacity can be made.
3. The frequency with which a patient receives physical or occupational therapy must be individualized by the attending physician.
4. Physical or occupational therapy occasionally continues beyond the time period during which pain control interventions such as sympathetic blocks are administered. Such prolonged therapy will be authorized as long as there is evidence of ongoing improvement of function of the limb.
5. Patients need to understand they must use their symptomatic limb in the course of their usual daily activities as well as during physical or occupational therapy sessions. Patients must commit themselves to physical restoration on a 24-hour per day basis.

B. Pain Control

1. Interventions to reduce pain are typically needed so that patients can get enough relief to participate in an activation program.
2. It is crucial that pain control interventions be linked closely with physical/occupational therapy. Physical or occupational therapy sessions should be scheduled as soon as possible after a sympathetic block. The interval between block and therapy should always be less than 24-hours. In general, physical/occupational therapy should be directed toward activation and desensitization in the affected limb. Details are given in [Table 2](#).
3. Clinicians use a variety of medications to control pain in patients with CRPS. These include alpha adrenergic blockers, corticosteroids, antidepressants, anti-seizure medications, mexiletine and opiates. The Department of Labor and Industries has no formal guideline regarding a specific medication regimen for CRPS.

C. Sympathetic Blocks

1. In a patient who meets criteria for CRPS, up to 3 sympathetic blocks will be authorized to allow the attending physician to determine whether the patient has sympathetically mediated pain.
2. Additional blocks will be authorized ONLY if there is evidence from the first three that the patient has sympathetically mediated pain.
3. The physician who performs each sympathetic block should document:
 - (a) Measurable evidence that a sympathetic blockade in the target limb was achieved – e.g., hand/foot temperature before and after the block, observed color changes and/or venodilation.
 - (b) The extent and duration of the patient's pain relief, based on a pain diary.
4. A patient should be seen by a physical or occupational therapist during the time interval when a sympathetic block would be expected to have an effect – that is, within a few hours of the block. The therapist should document the functional status of the patient's symptomatic limb during the therapy session.
5. The attending physician or the physician performing sympathetic blocks should correlate the information previously described in #3 and #4 to determine whether a block has produced the intended effects on pain, function and observable manifestations of CRPS.

D. Psychological Treatment

The clinical course of many patients with chronic pain, such as those with CRPS, may be complicated by pre-existing or concurrent psychological or psychosocial issues. A one time

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psychological/psychiatric consultation may be requested to assist in the evaluation of such patients.

For those patients you feel require treatment for psychological/psychiatric disorders, authorization for such treatment will be considered only under the following conditions:

The psychological/psychiatric consultation has led to a psychiatric diagnosis (that is, a DSM4 diagnosis),

- AND**
- 1) **EITHER** the diagnosed psychiatric condition must be considered causally related to the industrial injury,
 - 2) **OR** the diagnosed condition must be retarding recovery from the industrial injury.

E. Treatment Phases

Treatment is divided into six-week phases. A maximum of three phases may be authorized. The second phase will be authorized only if the first phase has led to demonstrable functional improvement. The third phase may be authorized only if the first and second phases have led to demonstrable functional improvement.

1. In the first six-week phase, up to 5 sympathetic blocks will be authorized (along with other accepted conservative measures such as medication management).
2. During the second six-week phase, a total of 3 sympathetic blocks will be authorized.
3. Up to 3 more sympathetic blocks may be authorized for patients who go on to the third phase of treatment.

F. Hospitalization

Hospitalization is rarely appropriate in the treatment of CRPS. The only exception to this is that a CRPS patient might have an orthopedic condition that is amenable to surgery. Because CRPS patients are at high risk for flares after surgery, it is reasonable for such a patient to be admitted to a hospital prior to surgery so that aggressive pain control measures may be undertaken preoperatively.

G. Sympathectomy

Sympathectomies are not indicated for CRPS and are NOT COVERED.

8. REFERENCES

1. Janig W & Stanton-Hicks M (ed) Reflex Sympathetic Dystrophy: A Reappraisal. Seattle: IASP Press, 1996.
2. Merskey H & Bogdud N (ed) Classification of Chronic Pain (2nd ed). Seattle: IASP Press 1994.

Medical Treatment Guidelines

Table 1
Labor and Industries
Criteria Number 13
Chronic Regional Pain Syndrome (CRPS)
Conservative Treatment Guideline

EXAMINATION FINDINGS & DIAGNOSTIC TEST RESULTS	CONSERVATIVE CARE
<p style="text-align: center;">At least four of the following must be present in order for a diagnosis of CRPS to be made.</p> <p style="text-align: center;"><u>EXAMINATION FINDINGS:</u></p> <ol style="list-style-type: none"> 1. Temperature/color change 2. Edema 3. Trophic skin, hair, nail growth abnormalities 4. Impaired motor function 5. Hyperpathia/allodynia 6. Sudomotor changes <p style="text-align: center;"><u>DIAGNOSTIC TEST RESULTS</u></p> <ol style="list-style-type: none"> 7. Three-phase bone scan that is abnormal in pattern characteristics for CRPS. This test is not needed if 4 or more of the above examination findings are present. <p style="text-align: center;">SURGICAL INTERVENTION (SYMPHETECTOMY) FOR TREATMENT OF THIS CONDITION IS <u>NOT COVERED</u></p>	<p>Early aggressive care is encouraged. Emphasis should be on improved functioning of the symptomatic limb.</p> <p><u>FIRST SIX WEEKS OF CARE:</u></p> <ul style="list-style-type: none"> - Sympathetic blocks, maximum of five. Each block should be followed immediately by physical/occupational therapy. - Physical/occupational therapy should be focused on increasing functional level (see <u>Table 2</u>). - Other treatment, e.g., medication at MD's discretion as long as it promotes improved function. <p style="text-align: center;"><u>AFTER THE 1ST SIX WEEKS OF CARE:</u></p> <ul style="list-style-type: none"> - Strongly consider psychiatric or psychological consultation if disability has extended beyond 3 months. - Continued physical/ occupational therapy based on documented progress towards goals established during first 6 weeks (referenced above). - Sympathetic blocks only if response to previous blocks has been positive, maximum of 3** every six weeks for a maximum of 12 weeks. <p>**A maximum of 11 blocks can be delivered over the total 18 week period.</p>

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Table 2

Labor and Industries Criteria Number 13 Chronic Regional Pain Syndrome (CRPS) Conservative Treatment Guideline

PROTOCOL FOR PHYSICAL THERAPY/OCCUPATIONAL THERAPY FOR CRPS

- 1. Evaluation should:**
 - A.** Include a date of onset of original injury (helpful in determining if early or late stage) and a date of onset of the CRPS symptoms.
 - B.** Establish a baseline for strength and motion.
 - C.** Establish a baseline for weight bearing for lower extremity.
 - D.** If lower extremity, evaluate distance able to walk and need for assistive device.
 - E.** If upper extremity, establish a baseline for grip strength, pinch strength and shoulder range of motion.
 - F.** If possible, objectify swelling (e.g., do volume displacements).
 - G.** Define functional limitations.
- 2. Set specific functional goals for treatment related to affected extremity.**
- 3. All treatment programs should include a core of:**
 - A.** A progressive active exercise program, including a monitored home exercise program.
 - B.** Progressive weight bearing for the lower extremity (if involved).
 - C.** Progressive improvement of grip strength, pinch strength and shoulder range of motion of the upper extremity (if involved).
 - D.** A desensitization program.
- 4. For specific cases, additional treatment options may be indicated to enhance effectiveness of the above core elements. Documentation should reflect reasons for these additional treatment options.**
- 5. Documentation should include:**
 - A.** At least every two weeks, assessment of progress towards goals.
 - B.** Response to treatment used in addition to core elements (listed above in section 3).
 - C.** Evidence of motivation and participation in home exercise program, i.e., diary or quota system.

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Fibromyalgia

Purpose

Fibromyalgia is a complex pain disorder that raises many questions for providers, particularly as to whether this condition is related to the industrial insurance system. The purpose of this bulletin is to answer a few of those questions:

- Is fibromyalgia accepted as an industrial injury or occupational disease?
- If a provider asserts a worker's fibromyalgia is related to the industrial injury or occupational exposure, what type of documentation should be submitted to support this contention?
- Will the department or self-insurer pay for short-term treatment of fibromyalgia?

Is fibromyalgia accepted as an industrial injury or occupational disease?

The Office of the Medical Director at the Department of Labor & Industries, in collaboration with the Washington State Medical Association's Industrial Insurance Guideline Subcommittee, studied fibromyalgia and the medical literature that addresses the causes of fibromyalgia. After careful consideration, it was determined that there is not sufficient medical data at this time to establish a causal relationship between an industrial injury or occupational exposure and the subsequent development of fibromyalgia.

Based on this lack of scientific evidence, the department does not generally recognize fibromyalgia as an industrial injury, an occupational disease, or an aggravation to a pre-existing condition.

The worker's health care provider may submit additional information, as described below, that the provider believes rebuts, or challenges, this general policy for an individual worker.

Reference: Provider Bulletin 98-11; Date Introduced: November 1998

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If a provider asserts a worker's fibromyalgia is related to the industrial injury or occupational exposure, what type of documentation should be submitted to support this contention?

A provider who feels that a worker's fibromyalgia is causally related to an industrial injury or occupational disease is encouraged to submit additional information to support that diagnosis. The kinds of information useful in this regard include:

1. Case-specific information linking the injury to the occurrence of fibromyalgia, Case-specific information might include, but is not limited to:

- Evidence of a temporal relationship to the worker's industrial injury or occupational exposure (e.g. the injury precedes all symptoms of fibromyalgia or symptoms of potentially crossover disorders such as chronic fatigue syndrome),
- Documentation that the worker's diagnosis of fibromyalgia meets the American College of Rheumatology's 1990 Criteria for the Classification of Fibromyalgia (see attachment),
- A biological and clinically justifiable rationale for the relationship between the industrial injury and the occurrence of fibromyalgia. The biological rationale should include a discussion based on accepted principles of biological sciences (anatomy, physiology, biochemistry, etc.) as to how the industrial injury caused the condition.

2. Scientific studies that address the relationship between individual injuries and the occurrence of fibromyalgia.

The provider is encouraged to submit published scientific studies supporting the contention of causality. In 1996, and again in 1997 and 1998, the department reviewed the existing scientific literature on this subject and found insufficient medical data to establish a causal relationship between a traumatic injury or occupational exposure and the development of fibromyalgia. Therefore, it is particularly important that the provider point out any new studies or new analyses of old studies that he or she feels supports a different conclusion regarding causality.

Effective January 1, 1999, State Fund claim managers will automatically request this information from the attending physician whenever fibromyalgia is contended on a claim. Information submitted by the provider to support the causal relationship will be reviewed by department medical staff before a claim adjudication decision is made.

Will the department or self-insurer pay for short-term treatment of fibromyalgia?

Temporary treatment as an aid to recovery

In general, fibromyalgia is not an accepted condition and treatment is not allowed. However, if fibromyalgia is directly retarding recovery of the accepted industrial injury or occupational disease, the department or self-insurer may authorize temporary treatment per WAC 296-20-055. Temporary treatment can be authorized when all of the following conditions are met:

- The accepted industrial injury is not stable,
- Fibromyalgia is directly retarding recovery of the accepted industrial injury or occupational disease, and
- The required documentation is submitted (see authorization and documentation requirements below).

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Treatment as an aid to recovery will be authorized for no longer than 90 calendar days. If the worker has reached maximum recovery from the accepted industrial injury or occupational disease prior to the 90-day period, the fibromyalgia treatment will be terminated at that time.

What are the authorization requirements?

The provider must obtain prior authorization to treat fibromyalgia as an aid to recovery. The department or self-insurer will not pay for treatment for fibromyalgia as an unrelated condition unless specifically authorized.

To request prior authorization, the provider must submit the following in writing to the department or self-insurer:

- Adequate documentation that the worker's diagnosis of fibromyalgia meets the American College of Rheumatology's (ACR) 1990 Criteria for the Classification of Fibromyalgia (see attachment A),
- An explanation of how fibromyalgia, as an unrelated condition, is affecting the accepted industrial condition, and
- A treatment plan.

Note: The State Fund's Provider Toll Free staff will not be able to authorize these services.

What type of treatment may be allowed for the temporary treatment of fibromyalgia?

The department or self-insured employer is most likely to approve treatment plans that include conservative, non-invasive treatment that the scientific literature has shown to be effective in the short term. Such treatment includes, but may not be limited to:

- Physical therapy,
- Low dose tricyclic anti-depressants,
- Muscle relaxants on a time-limited basis, or
- Spinal manipulations.

The department or self-insured employer will **not** approve invasive therapies or treatments whose effectiveness has not been documented for even the short-term. The following types of treatment will not be approved for the treatment of fibromyalgia:

- Trigger point injections,
- Methotrexate,
- Opioids, or
- NSAIDS.

Note: Fibromyalgia may coexist with other conditions for which such therapies may be indicated.

What are the documentation requirements?

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When treating an unrelated condition, the attending physician must submit a report every 30 days outlining the effect of the treatment on both the unrelated and the accepted industrial conditions.

Because fibromyalgia does not have a unique diagnosis code, we ask that providers use ICD.9 code 729.1 (myalgia) on bills submitted for treatment of fibromyalgia.

Where is more information available?

Temporary treatment of unrelated conditions when retarding recovery

WAC 296-20-055

Criteria for the classification of fibromyalgia

- Enclosed summary, attachment A.
- Frederick Wolfe, et.al., "The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia, Report of the Multicenter Criteria Committee," *Arthritis and Rheumatism*, Vol. 33, No. 2, (February 1990).

The American College of Rheumatology's 1990 Criteria for the Classification of Fibromyalgia*

For classification purposes, patients will be said to have fibromyalgia if both criteria are satisfied. Widespread pain must have been present for at least 3 months. The presence of a second clinical disorder does not exclude the diagnosis of fibromyalgia.

1. History of widespread pain.

Pain is considered widespread when all of the following are present: pain in the left side of the body, pain in the right side of the body, pain above the waist, and pain below the waist. In addition, axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) must be present. In this definition, shoulder and buttock pain is considered as pain for each involved side. "Low back" pain is considered lower segment pain.

2. Pain, on digital palpation, must be present in at least 11 of the following 18 tender point sites:

Occiput - bilateral, at the suboccipital muscle insertions
Low cervical - bilateral, at the anterior aspects of the intertransverse spaces at C5-C7
Trapezius - bilateral, at the midpoint of the upper border
Supraspinatus - bilateral, at origins, above the scapula spine near the medial border
Second rib - bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces
Lateral epicondyle - bilateral, 2 cm distal to the epicondyles
Gluteal - bilateral, in upper outer quadrants of buttocks in anterior fold of muscle
Greater trochanter - bilateral, posterior to the trochanteric prominence
Knee - bilateral, at the medial fat pad proximal to the joint line

Digital palpation should be performed with an approximate force of 4 kg. For a tender point to be considered "positive" the subject must state that the palpation was painful. "Tender" is not to be considered "painful".

* Frederick Wolfe, et.al., "The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia, Report of the Multicenter Criteria Committee", *Arthritis and Rheumatism*, Vol. 33, No. 2 (February 1990)

Guidelines for Outpatient Prescription of Controlled Substances, Schedules II-IV, For Workers on Time-Loss

L&I, in collaboration with the Washington State Medical Association, has developed two guidelines on the topic of opioids and controlled substances. These two guidelines have some areas of overlap, and some content found in one but not the other guideline. Therefore, both guidelines are included in this publication.

On the following pages you will find the first of the two guidelines, developed in 1992 and 2000. The second guideline, dealing with opioids, is located in a separate section.

Below is a table summarizing some of the differences between the two guidelines.

It is hoped that clinicians will find both guidelines helpful, depending on the circumstances of each individual patient.

1992 Guideline on Controlled Substances	2000 Guideline on Opioids
<ul style="list-style-type: none">• Relates to all controlled substances, not just opioids• Deals with treatment in the acute and subacute phases• Includes special tools helpful to clinicians, such as:<ul style="list-style-type: none">○ A useful chart listing examples of Schedule II, III, and IV controlled substances○ A list of relative contraindications for the use of controlled substances○ 3 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in <i>Attending Doctor's Handbook</i>○ Handy patient education sheet, with a message from the Washington State Medical Association• Includes a guideline only, with no absolute requirements in regulation or law	<ul style="list-style-type: none">• Relates primarily to opioids• Deals primarily with chronic phase• Includes special tools helpful to clinicians, such as:<ul style="list-style-type: none">○ Sample Opioid Treatment Agreement○ Functional Progress Form (optional)○ Opioid Progress Report (required)○ 2 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in Provider Bulletin 00-04○ Billing information so providers may be reimbursed for services described• Includes the guideline, accompanied by regulations (WACs) and the 1998 Guideline from the Department of Health

Guidelines for Outpatient Prescription of Controlled Substances, Schedules II-IV, For Workers on Time-Loss

Developed by the Washington State Medical Association and the Washington State Department of Labor and Industries.
Adopted 1992 by the Washington State Medical Association Industrial Insurance and Rehabilitation Committee

INTRODUCTION

Purpose of the Guidelines

Repeated, long-term use of prescription controlled substances for chronic nonmalignant pain may be a factor in the development of long-term disability. This condition may be preventable if at-risk patients and practices are proactively identified and managed appropriately.

It is hoped that the prescribing guidelines listed below will lead to more accurate and timely identification of workers at risk for the development of long-term disability. These guidelines may also be a component of future intervention strategies aimed at preventing long-term disability.

Development of the Guidelines

These guidelines were developed by the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee and the Washington State Department of Labor and Industries. They are based on information from existing prescription guidelines, literature reviews, pharmacologic and medical references, seminars, interviews of experts, and consultations with physicians who have private practices in a wide variety of specialties.

Application of the Guidelines

The guidelines are intended for use in the management of chronic nonmalignant pain. Chronic nonmalignant pain is defined as pain persisting beyond the expected normal healing time for an injury, for which traditional medical approaches have been unsuccessful. Application of these guidelines is intended only for outpatient prescriptions of nonparenteral controlled substances. The nonparenteral routes of administration are considered the only acceptable routes for treating chronic nonmalignant pain in the Washington state workers' compensation system (WAC 296-20-03014).

It is recognized that the guidelines cannot apply uniformly to every patient. Also, the guidelines cannot be the sole determining basis for identifying patients at risk for a drug use problem or currently experiencing a drug use problem. Mere application of the guidelines cannot substitute for a thorough assessment of the patient or medical file by qualified health care professionals. For example, it may be acceptable to prescribe opioids to workers who are gainfully employed and not receiving time-loss. Similarly, the guidelines cannot substitute for detailed prescribing information found in many medical and pharmacologic references.

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Date Introduced: 1992

These guidelines will be applied in the workers' compensation setting only. The guidelines will apply only to workers whose injuries occurred after the guidelines are adopted by WSMA and sufficient notice has been given to providers. ***The Department of Labor and Industries may impose sanctions if the guidelines are not followed.***

The guidelines are intended for use by physicians who begin treatment within 6 months of the worker's injury. Patients who have been on controlled substances for prolonged periods and come under the care of a new physician present special problems. These and other problems will be dealt with in a separate publication.

Finally, while the guidelines may not conflict with state or federal laws, by necessity they cannot cover in detail all of the many rules, regulations, and policies published by the various agencies enacting and enforcing these laws.

Table 1

Documentation Recommendations When Controlled Substances Are Prescribed

- a. A thorough medical history and physical examination and medical decision-making plan should be documented, with particular attention focused on determining the cause(s) of the patient's pain.
- b. A written treatment plan should be documented and should include the following information:
 - a finite treatment plan that does not exceed six weeks.
 - clearly stated, measurable objectives.
 - a list of all current medications (with doses) including medications prescribed by other physicians (whenever possible).
 - description of reported pain relief from each medication.
 - justification of the continued use of controlled substances.
 - documentation of attempts at weaning.
 - explanation of why weaning attempts have failed (including detailed history to elicit information on alcohol and drug use).
 - how the patient's response to medication will be assessed.
 - further planned diagnostic evaluation.
 - alternative treatments under consideration.
- c. The risks and benefits of prescribed medications should be explained to the patient and the explanation should be documented, along with expected outcomes, duration of treatment, and prescribing limitations.
- d. The treatment plan should be revised as new information develops which alters the plan.

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Table 2
Relative Contraindications For The Use Of
Controlled Substances

1. <i>History</i> of alcohol or other substance abuse, or a history or chronic, high dose of benzodiazepine use.
2. <i>Active</i> alcohol or other substance abuse.
3. <i>Borderline</i> personality disorders.
4. <i>Mood disorders</i> (e.g., depression) or psychotic disorders.
5. <i>Other</i> disorders that is primarily depressive in nature.
6. <i>Off work</i> for more than 6 months.
* Note: When special circumstances seem to warrant the use of these drugs in the types of patients noted above, referral for review is indicated.

General Information

- A. Please refer to the "Introduction" for more information on the purpose, development, and application of these guidelines

PHYSICIANS MAY BE HELD ACCOUNTABLE IF THEIR
PRESCRIBING PATTERNS FALL OUTSIDE THESE GUIDELINES.

- B. Documentation recommendations (as presented in Table 1) should be followed at all times, especially whenever the physician departs from the guidelines listed below.

TREATMENT OF ACUTE PAIN FROM TRAUMATIC INJURIES OR SURGERY (POST-DISCHARGE):

- A. Schedule II drugs should be prescribed for no longer than 2 weeks.
- B. Schedule III and Schedule IV drugs should be prescribed for no longer than 6 weeks. (See Table 3 for examples of controlled substances.)

TREATMENT OF CHRONIC NON-MALIGNANT PAIN*:

- A. **EXTREME CAUTION** should be used in prescribing controlled substances for workers with one or more "Relative Contraindications" (see Table 2).
(NOTE: When special circumstances seem to warrant the use of these drugs in the types of patients listed in Table 2, referral for review is indicated.)
- B. For patients on a **combination** of opioids and scheduled sedatives:

TREATMENT WITH COMBINATIONS SHOULD USUALLY NOT
EXTEND BEYOND 6 WEEKS.

- C. For patients on opioids **OR** scheduled sedatives (but not combinations of the two):

TREATMENT SHOULD USUALLY NOT EXTEND BEYOND 3 MONTHS.

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D. Consultation or referral to a chronic pain specialist should be considered when any of the following conditions exist:

1. Underlying tissue pathology is minimal or absent, **AND** correlation between the structural derangement caused by the original injury and the severity of impairment is not clear;
 2. Suffering and pain behaviors are present, and the patient continues to request medication; or
 3. Standard treatment measures have not been successful or are not indicated.
- * Defined as pain persisting beyond the expected healing time for an injury which traditional medical approaches have been unsuccessful.

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Table 3		
Examples Of Controlled Substances*		
SCHEDULE II	SCHEDULE III	SCHEDULE IV
<p style="text-align: center;"><u>OPIOIDS:</u></p> <p>codeine fentanyl (Sublimaze, Innovar) hydromorphone (Dilaudid) levorphanol (Levo-Dromoran) meperidine (Demerol) meperidine w/ Promethazine (Mepergan) methadone (Dolophine) morphine (MS Contin, MSIR, OMS, RMS, Roxanol) oxycodone oxycodone w/ acetaminophen/aspirin (Percocet, Percodan, Roxicet, Roxiprin, Tylox)</p>	<p style="text-align: center;"><u>OPIOIDS:</u></p> <p>acetaminophen with codeine (Codalan, Phenaphen 2, 3, 4, Tylenol 2, 3, 4) aspirin with codeine (Empirin 2, 3, 4) hydrocodone hydrocodone w/ acetaminophen/aspirin (Anexsia, Azdone, Bancap, Cogesic, Damason-P, Dolacet, Duocet, Endal-HD, Hyco-Pap, Hydrocet, Hyphen, Lorcet Plus, Lorcet HD, Lortab, Vicodin, Zydone) nalorphine paregoric</p>	<p style="text-align: center;"><u>OPIOIDS:</u></p> <p>propoxyphene (Darvon) propoxyphene w/ acetaminophen/aspirin (Darvocet, Dolene, Wygesic) pentazocine (Talwin)</p>
<p style="text-align: center;"><u>SEDATIVES:</u></p> <p>amobarbital (Amytal)** secobarbital (Seconal)** pentobarbital (Nembutal)**</p>	<p style="text-align: center;"><u>SEDATIVES:</u></p> <p>any compound containing an unscheduled drug and: amobarbital ** secobarbital** pentobarbital** glutethimide (Doriden)</p> <p><u>Non-narcotic Analgesic Combinations</u> butalbital with acetaminophen/aspirin (fiorinal)</p>	<p style="text-align: center;"><u>SEDATIVES:</u></p> <p>chloral hydrate clorazepate (Tranxene) chlordiazepoxide (Librium) clonazepam (Klonopin) diazepam (Valium) ethchlorvynol (Placidyl) flurazepam (Dalmane) meprobamate (Equanil, Miltown) oxazepam (Serax) paraldehyde (Paral) phenobarbital ** prazepam (Centrax) triazolam (Halcion)</p>
<p>* This table is not intended as an exhaustive listing of controlled substances. A few trade names have been given as examples. This listing should in no way be construed as an endorsement of any medication.</p> <p>** Barbiturates are not paid for by the Department at any time (except phenobarbital, which is allowed only for seizure disorders).</p>		

TO OUR PATIENTS

**WHAT YOU SHOULD KNOW ABOUT RULES
YOUR DOCTOR MUST FOLLOW TO
PRESCRIBE DRUGS THAT MAY BE
ADDICTIVE.**

The Washington State Medical Association (WSMA) and the Department of Labor and Industries (L&I) believe that it may do you more harm than good to take addicting drugs for a long time.

Guidelines approved by the Washington State Medical Association must be followed by your physician.

**SO PLEASE HELP YOUR PHYSICIAN TO HELP YOU --
FOLLOW YOUR DOCTOR'S INSTRUCTIONS CAREFULLY.**

THANK YOU!

A message from the Washington State Medical Association.

To the doctor: Please feel free to photocopy this sheet and distribute to your patient, preferably along with your first prescription for controlled substance.

Medical Treatment Guidelines

Selected References

The following are a few of the published materials used to prepare these guidelines.

AHFS Drug Information '91, American Hospital Formulary Service, by the American Society of Hospital Pharmacists, Inc., Bethesda, MD, 1991.

“Chronic Opioid Therapy in Nonmalignant Pain,” RK Portenoy, Journal of Pain and Symptom Management, Vol. 5, No. 1 (Suppl.) February 1990, pp. S46-S62.

Guidelines for Prescribing Controlled Substances for Chronic Conditions, California Medical Association, San Francisco, CA, April 12, 1985.

“Medications in Low Back Pain,” JP Robinson and PB Brown, Physical Medicine and Rehabilitation Clinics of North America, Vol. 2, No. 1, February 1991, pp. 97-125.

“Prescribing Practices for Pain in Drug Dependence: A Lesson in Ignorance,” LM Halpern and JP Robinson, Controversies in Alcoholism and Substance Abuse, The Haworth Press, Inc., 1986.

“Unlocking the Secrets of Pain — The Treatment — A New Era,” JD Loeser, Medical and Health Annual Encyclopedia Britannica, 1988 pp 120-31.

Guidelines for Outpatient Prescription of Oral Opioids for Injured Workers with Chronic, Noncancer Pain

L&I, in collaboration with the Washington State Medical Association, have developed two guidelines on the topic of opioids and controlled substances. These two guidelines have some areas of overlap, and some content found in one but not the other guideline. Therefore, both guidelines are included in this publication.

On the following pages you will find the second of the two guidelines, developed in May, 2000. The first guideline, dealing with controlled substances, is located in a separate section.

Below is a table summarizing some of the differences between the two guidelines.

It is hoped that clinicians will find both guidelines helpful, depending on the circumstances of each individual patient.

1992 Guideline on Controlled Substances	2000 Guideline on Opioids
<ul style="list-style-type: none">• Relates to all controlled substances, not just opioids• Deals with treatment in the acute and subacute phases• Includes special tools helpful to clinicians, such as:<ul style="list-style-type: none">○ A useful chart listing examples of Schedule II, III, and IV controlled substances○ A list of relative contraindications for the use of controlled substances○ 3 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in <i>Attending Doctor's Handbook</i>○ Handy patient education sheet included, with a message from the Washington State Medical Association• Includes a guideline only, with no absolute requirements in regulation or law	<ul style="list-style-type: none">• Relates primarily to opioids• Deals primarily with chronic phase• Includes special tools helpful to clinicians, such as:<ul style="list-style-type: none">○ Sample Opioid Treatment Agreement○ Functional Progress Form (optional)○ Opioid Progress Report (required)○ 2 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in Provider Bulletin 00-04○ Billing information so providers may be reimbursed for services described• Includes the guideline, accompanied by regulations (WACs) and the 1998 Guideline from the Department of Health

Medical Treatment Guidelines

GUIDELINES FOR OUTPATIENT PRESCRIPTION OF ORAL OPIOIDS FOR INJURED WORKERS WITH CHRONIC, NONCANCER PAIN

May 1, 2000

These guidelines were developed by the Washington State Department of Labor and Industries (L&I) in collaboration with the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee. These guidelines are intended to help doctors follow the 1998 *Guidelines for Management of Pain* issued by the Washington State Department of Health (DOH), and to apply the DOH guidelines to the care of injured workers with chronic, noncancer pain.

WHAT'S INSIDE

- Introduction **Page 74**
- A. Assessment, Management, and Documentation which patients should receive a trial of opioid therapy for chronic pain? How should I manage the trial? **Page 76**
- B. Long-term Issues what should I do if I have a patient who has already been on opioids for 6 months or more and is not back at work? **Page 79**
- C. Precautions in Prescribing what precautions should I take when prescribing opioids? What signs may I see in a person with a prescription opioid problem? **Page 80**
- Appendix 1: The Department of Health Guidelines the DOH *Guidelines* are presented in their entirety, including definitions of terms. **Pages 81-83**
- Appendix 2: The Basis for These Guidelines how were these guidelines and policies developed? What medical literature was used? **Pages 84-85**

HELPFUL TOOLS

Are there tools to help me follow all relevant recommendations?

- **A Simple Flowchart** shows key recommendations of the DOH *Guidelines for Management of Pain* and the L&I *Guidelines*. Please consider laminating this page for easy reference in your office. **Page 75**
- **The Opioid Treatment Agreement** is a template you can use in your practice. **Pages 86-87**
- **The Opioid Progress Report Supplement** is included to help you and your patient focus on ways to decrease pain and improve function while meeting reporting requirements. **Page 88**
- **The Functional Progress Form** consists of two graphs to help track your patient's progress from month to month. **Page 89**

Reference: Provider Bulletin 00-04;
Date Introduced: May 2000

Medical Treatment Guidelines

INTRODUCTION

Chronic, noncancer pain can be a complex and difficult management problem for both patient and physician. Chronic, noncancer pain may develop after an acute injury episode and is defined as pain that persists 2 - 4 months from the date of injury.

These guidelines are intended to help doctors to follow the 1998 *Guidelines for Management of Pain* issued by the Washington State Department of Health (DOH), and to apply the DOH guidelines to the care of injured workers with chronic, noncancer pain.

Long-term opioid use for chronic, noncancer pain is based on changing community standards and a body of evidence based on case reports of series of patients. There are few well-controlled or randomized controlled studies on the use of opioids in chronic pain states. There are no studies evaluating the effects of opioid use for chronic, noncancer pain exclusively in a worker's compensation population.

Even in the absence of strong research evidence, the community standard for the treatment of chronic, noncancer pain is changing. Findings from case reports do suggest that with appropriate patient selection and careful monitoring, opioid treatment

can be effectively provided. Thus, a trial of opioid medications may be warranted.

These guidelines were developed by the Washington State Department of Labor and Industries (L&I) in collaboration with the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee. The guidelines are based on information from existing guidelines, extensive literature reviews, pharmacologic and medical references, interviews of experts and consultations with physicians in a wide variety of specialties. Careful, regularly documented compliance with these guidelines is necessary for the safety of injured workers, and to further the goal to return injured workers to health and to work.

Please note: The medical care a patient receives is a matter of choice for the patient to make in consultation with a treating physician. This principle is the same in cases with and without workers' compensation issues. Payment for medical care involves issues that may be distinct from treatment decisions. The Department of Labor and Industries pays for only that medical care which meets the requirements of the Washington Administrative Code and cannot pay for opioids once the patient reaches maximum medical improvement.

**For which patients should I use these guidelines and why were the guidelines developed?
*Please use these guidelines for all injured workers with chronic pain who are taking opioids.***

These guidelines are intended to supplement the 1998 *Guidelines for Management of Pain* issued by the Washington State Department of Health (see Appendix 1, pages 81-83). L&I endorses and encourages compliance with the DOH *Guidelines*. Since the *Guidelines for Management of Pain* were issued, problems of both under-treatment and over-treatment with controlled substances continue. L&I feels there is a need to make it easier for providers to follow the DOH *Guidelines* while treating injured workers, especially the sections on documentation.

Also, L&I must consider factors such as whether care is curative or rehabilitative and whether a worker has reached a stable plateau from which further recovery is not expected (maximum medical improvement or MMI). *

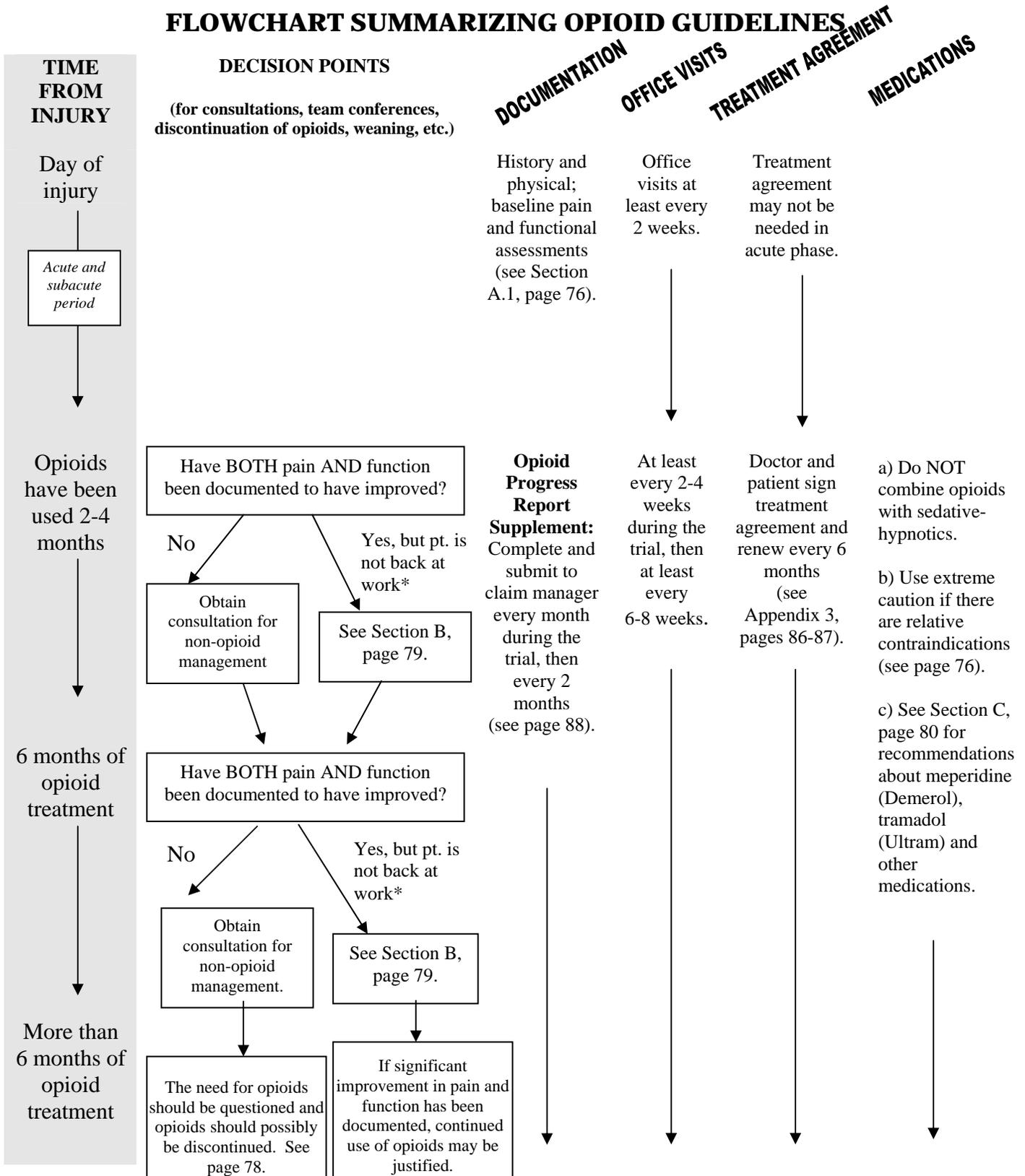
In addition, operating heavy machinery, driving motor vehicles and other work activities may be dangerous to your patient and to his/her co-workers if controlled substances are being used. Your patient's livelihood may be affected for this reason.

Such considerations created a need to supplement the DOH *Guidelines for Management of Pain* for the worker population.

* For details, please refer to L&I's Medical Aid Rules (WAC 296-20-01002, WAC 296-20-03019 and WAC 296-20-03022).

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FLOWCHART SUMMARIZING OPIOID GUIDELINES



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* If pain and function have improved and patient has returned to work, please refer to Section F.8. "Assessment and Monitoring" of the DOH Guidelines on pages 82-83.

SECTION A. ASSESSMENT, MANAGEMENT AND DOCUMENTATION

1. How do I assess whether a formal trial of opioids for chronic pain is indicated?

You should address several questions to decide if a formal trial of opioids for chronic pain is indicated:

1) Are there reasonable alternatives other than opioids? 2) Is the patient likely to improve with opioids? and 3) Is the patient likely to abuse opioids or have other adverse outcomes? See Table 1 below for guidance on the latter two questions.

For guidance in the acute and subacute phases, refer to the "Guidelines for Outpatient Prescription of Controlled Substances for Workers on Time-Loss," developed in 1992 by L&I in collaboration with the Washington State Medical Association. These may be found in the *Attending Doctor's Handbook*, obtained by calling 1-800-848-0811.

Beyond 2-4 months of acute/subacute opioid use, the following assessment is strongly recommended:

- a) Perform a baseline history and physical, including pain history and the impact of pain on the patient, a complete exam, review of previous diagnostic and therapeutic results and an assessment of co-existing conditions.
- b) Obtain relevant baseline clinical or laboratory studies and/or urine drug screen, as indicated.
- c) Based on the results of your assessment, identify the pain diagnosis. (See Table 1.)
- d) Baseline pain and functional assessments should be documented. You may find it helpful to use a form like the attached *Opioid Progress Report Supplement* on page 88. **Function includes**

(Continued on next page)

TABLE 1. HOW TO ASSESS WHETHER AN OPIOID TRIAL IS INDICATED

1) IS THE PATIENT LIKELY TO IMPROVE?

MAY IMPROVE

- 1) Patient has taken opioids in the acute and subacute phases with some improvement in pain and function.
- 2) Other conservative measures have failed (NSAIDs, etc.) and opioids have not been tried.
- 3) Your pain diagnosis falls into one of the following three categories:
 - a) Nociceptive pain (for example, ischemia, tissue destruction, arthritis, cancer, arachnoiditis).
 - b) Neuropathic pain (for example, sciatica, carpal tunnel syndrome, trigeminal neuralgia, post-herpetic neuralgia, phantom limb pain).
 - c) Mixed nociceptive and neuropathic pain.

PROBABLY WILL NOT IMPROVE

- 1) Patient has taken opioids in the acute and subacute phases with NO improvement in pain and function (assuming appropriate dosing, etc.).
- 2) The pain diagnosis falls into the category of somatoform disorder. A consultation should be considered to address the underlying problem. In particular, conversion disorder, somatization disorder, or pain disorder associated with psychological factors (DSM-IV 307.80) is associated with poor response to opioids.

2) IS THE PATIENT LIKELY TO ABUSE OPIOIDS OR HAVE OTHER ADVERSE OUTCOMES?

- The risk of abuse or adverse outcome is high if any of the following are present:
- 1) History of alcohol or other substance abuse, or a history of chronic, high dose benzodiazepine use.
 - 2) Active alcohol or other substance abuse.
 - 3) Borderline personality disorders.
 - 4) Mood disorders (e.g., depression) or psychotic disorders.
 - 5) Other disorders that are primarily depressive in nature.
 - 6) Off work for more than 6 months.
 - 7) Poor response to opioids in the past.

Note: When special circumstances seem to warrant the use of these drugs in the types of patients noted above, referral for review is indicated.

Medical Treatment Guidelines

social, physical, psychological, daily and work activities.

- e) Assess the worker's ability to participate in a return-to-work program, for example, work-hardening and vocational services.
- f) Assess likelihood the patient can be weaned from opioids in the event there is no improvement in pain and function.
- g) Decide whether you have the expertise to conduct a formal opioid trial for chronic pain. If not, make an appropriate referral.

Please note: In order for the Department of Labor & Industries or the self-insurer to pay for the opioid trial, the physician must submit a report no later than 30 days after beginning such treatment. (See WAC 296-20-03020 for details on the requirements of this report.)

2. How should I manage a formal trial of opioids for chronic pain?

The following general parameters should guide the attending physician's plan of care:

- a) **Second opinion:** Consider a second opinion before planning the trial of opioids to assess whether a trial is indicated, and if so, how it should be conducted.
- b) **Documentation: You should use the one-page Opioid Progress Report Supplement, page 88.** This will help you comply with all documentation requirements of the Department of Labor and Industries. (See WAC 296-20-03021 and 296-20-03022.)

Using the one-page Opioid Progress Report Supplement will also serve as a step-by-step guide to remind you and your patient to address a number of key issues, such as the treatment agreement, screening for addiction, return-to-work efforts, assessment of functional progress, consultations, medication history, treatment plan, etc.

- c) **Contingency plan:** Plan ahead of time for both of these possibilities:
 - 1) The patient needs to be weaned from opioids because there has been no improvement in pain and function.
 - 2) Continuation of opioids beyond maximum medical improvement is indicated, and other forms of payment for the medications will be needed.
- d) **Treatment agreement:** You and your patient should together sign a treatment agreement

that outlines: the risks and benefits of opioid use, the conditions under which opioids will be prescribed, the physician's need to document overall improvement in function, and worker responsibilities (See Appendix 3, pages 86-87, Sample Opioid Treatment Agreement).

Safety risks: Patients should especially be warned about potential side effects of opioids such as increased reaction time, clouded judgment, drowsiness and tolerance. Also, they should be warned about the possible danger associated with the use of opioids while operating heavy equipment or driving.

- e) **Helping your patient return to work:** You should participate in a team conference with your patient, the employer (or potential new employers), the claim manager, the vocational counselor and others (preferably face-to-face) to explore return-to-work options. Which parties need to be involved will vary with each situation. Phone conferences often work well.

For more information on resources available to you, see the Attending Doctor's Handbook (available at 1-800-848-0811).

- f) **Principles for prescription of opioids:** You should follow these general principles:
 - 1) **Single prescribing physician:** There should be a single prescribing physician for all controlled substances.
 - 2) **Single pharmacy:** You should use a single pharmacy for prescription filling (whenever possible).
 - 3) **Lowest possible dose:** The lowest possible effective dose should be used to initiate therapy, and should be titrated, as needed to minimize both pain and medication side effects and maximize pain management and increased functioning.
 - 4) **Appearance of misuse of medications:** Be sure to watch out for and document any appearance of misuse of medications. Acquisition of drugs from other physicians, uncontrolled dose escalation or other aberrant behaviors must be carefully assessed. In all such patients, opioid use should be reconsidered and additional, more rigid guidelines applied if opioids continue. In some cases, tapering and discontinuation of opioid therapy will be necessary.
- g) **Visit frequency:** Visits initially at least every 2 weeks for the first 2-4 months of the trial,

Medical Treatment Guidelines

then at least once every 6-8 weeks while receiving opioids.

h) **Consultations:** You should request a consultation if:

- 1) A dose in excess of 100-150 mg of oral morphine daily or its equivalent (for example, 45 mg of MS Contin every 8 hours) is being used;
- 2) Pain and functional status have not substantially improved after 3 months of opioid treatment;
- 3) A patient has a history of chemical dependency; or
- 4) A patient appears to have significant problems with depression, anxiety or irritability (a psychologic consultation may be indicated in these cases).

i) **Laboratory studies and drug screens:** Remember to order relevant ongoing clinical or laboratory studies (especially liver or kidney function screens), including drug screens, as indicated.

j) **Discontinuation vs. continuation of opioids:** After 6 months of a well-designed opioid trial, a physician should determine whether opioid therapy is appropriate for the patient, in accordance with the following:

- 1) If there has not been an overall improvement in function, opioids should usually be discontinued. (If there are extenuating circumstances that justify further use of opioids after 6 months of an opioid trial, these should be described in detail.)

- 2) If the patient has returned to work or has demonstrated substantial improvement both in function and reported pain level during a 6-month opioid trial, reasonable doses of opioids could continue. However, you and your patient should understand that state law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. Please refer to L&I's *Medical Aid Rules* WAC 296-20-03019 through 296-20-03024 for further details. You should speak with your patient about other sources of payment for opioids when L&I can no longer pay. With this in mind, you should re-evaluate the need for opioids every two months, using techniques such as weaning and/or substitution of alternative treatments.

- 3) **Weaning time:** Weaning can be done safely by way of a slow taper. Patients who undergo intensive treatment programs in a pain center or a drug rehabilitation center can be tapered off opioids in 1-2 weeks. Patients being treated in an office-based practice should be tapered more slowly, but the taper should never take more than 3 months.

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SECTION B. LONG-TERM ISSUES

1. What should I do if I have a patient who has *already* been on opioids for 6 months or more and is not back at work (or if I accept a *new* patient like this)?

If a patient has already received opioids for six months or more, you should do the following:

- a) **Re-assess:** Perform a thorough re-assessment of the patient to see if anything has been missed.
 - 1) Is the original diagnosis still present? Are there additional diagnoses that may contribute to the pain?
 - 2) Has the patient been given other medications for management of pain? If so, how effective were they, what side effects were experienced and how severe were the side effects?
 - 3) Has the patient tried other treatment methods or consulted with other specialists? If so, what alternative methods have been tried, length of alternative treatments, effectiveness, and/or specialist recommendations and effectiveness of those recommendations?
 - 4) Has there been functional improvement since opioids were started? Try to quantify the improvement.
 - 5) Would a psychological or psychiatric evaluation, completed by a psychiatrist or psychologist experienced in evaluating chronic pain patients, be helpful or necessary for you to determine effective pain management for this patient? Or has the patient completed a similar evaluation within the last 3-6 months? Psychosocial issues include motivation, attitude about pain/work, return-to-work options, home life, etc.
 - 6) Has screening for elements of addiction been completed? Special caution should be exercised in patients with a history of substance abuse that cannot be attributed to a past mistaken diagnosis of addiction because this patient previously used opiates for pain management. Have you reviewed prior medical records, including L&I medical records and drug summaries? A

drug summary may be obtained from the claim manager.

- 7) Review Sections A2, C1 and C2 for guidance on re-assessment and documentation. The essential material in these sections, particularly the treatment plan and its relationship to recovery, should be covered in your summary.

- b) **Summarize:** Provide the insurer and others involved in the patient's care with a written summary of the case. Special attention should be given to the history of opioid use (how long, in what doses, etc.). Give a clear statement of your rationale if you think opioid treatment should continue.
- c) **Help the patient return to work:** You should participate in a team conference with the patient, the employer (or potential new employers), the claim manager, the vocational counselor and others (preferably face-to-face) to explore return-to-work options. Which parties need to be involved will vary with each situation. Phone conferences sometimes work well.

For more information on resources available to you and how to bill for these services, see the Attending Doctor's Handbook (available at 1-800-848-0811).

- d) **Triage:** If the patient has been treated with opioids for 6 months or more, you should **automatically** review the case as described in **a)** through **d)**. At that point the physician should choose one of three pathways:

- 1) Modify the treatment plan to achieve optimum opioid benefit. Many patients like this will be taking combinations of medications that don't offer optimal pain control.
- 2) Discontinue opioid therapy.
- 3) Continue in opioid therapy.

In the third pathway, plans could be made to eventually move from the long-term opioid pathway up to one of the other pathways.

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SECTION C. PRECAUTIONS IN PRESCRIBING

1. What precautions should I take when prescribing opioids?

a) **DO NOT USE:**

Opioids in combination with sedative-hypnotics (such as benzodiazepines or barbiturates) for chronic, noncancer pain.

(There may be specific indications for such combinations, such as the co-existence of spasticity. In such cases, a consultation is strongly recommended.)

b) **Use of these medications is NOT RECOMMENDED:**

1. Meperidine, which should not be prescribed for chronic pain.
2. Tramadol (Ultram) in combination with other opioids.
3. Carisoprodol (Soma).
4. Combination agonists and mixed agonists/antagonists. Mixed agonists/antagonists include such drugs as butorphanol (Stadol); dezocine (Dalgan), nalbuphine (Nubain) and pentazocine (Talwin).
5. Barbiturates (except if used to treat a seizure disorder).
6. Outpatient prescriptions of parenteral dosage forms of any drug.

c) **Use caution when prescribing:**

1. Acetaminophen in doses greater than 4 grams (including, for example, combinations of drugs that include both an opioid and acetaminophen).
2. Cyclobenzaprine (Flexeril) in combination with tricyclic antidepressants (both share the same toxic potential).
3. Nonopioid drugs concomitantly with combination opioids (e.g., Tylenol given with Percocet).
4. Tramadol (Ultram) to patients at risk for seizures and/or who are also taking drugs which can precipitate seizures (e.g., SSRI antidepressants, tricyclic antidepressants).
5. Opioids, including tramadol, to patients with a prior or active history of chemical dependency.

d) Other recommendations include:

- Drug therapy should be individualized to the patient's specific pain condition and chosen on the basis of each drug's pharmacologic activity.
- Maintain patients on as few medications as possible. Drug interactions and adverse events increase as the number of medications in a regimen increases.
- Use adjuvant medications that are specific for a given pain condition.
- If possible, titrate only one drug at a time, while observing the patient for additive effects. Inappropriate medications should be tapered while initiating an appropriate pharmacologic regimen.

2. What signs may you see in a person with a prescription opioid problem?

The following guidelines were developed in a pain clinic setting. These guidelines may be a useful monitoring tool in managing chronic pain patients in your office setting. A patient may qualify as a prescription opiate abuser by meeting three or more of the criteria listed below. Physicians are encouraged to seek consultations (addictionologist, pain clinic, etc.) if 3 or more of these criteria are met. The patient:

- a) Displays an overwhelming focus on opioid issues. For example, discussion of opioids occupies a significant portion of the visit and impedes progress with other issues regarding the patient's pain. This behavior persists beyond the third clinic session.
- b) Has a pattern of early refills (3 or more) or escalating drug use in the absence of physician direction to do so.
- c) Generates multiple telephone calls or visits to the office to request more opioids, early refills, or problems associated with the opioid prescription. A patient may qualify with fewer visits if he or she creates a disturbance with the office staff.
- d) Demonstrates pattern of prescription problems for a variety of reasons that may include lost medications, spilled medications or stolen medications.
- e) Has supplemental sources of opioids obtained from multiple providers, emergency rooms or illegal sources.
- f) Has illicit drugs on urine screen.

Medical Treatment Guidelines

APPENDIX 1

DEPARTMENT OF HEALTH GUIDELINES FOR MANAGEMENT OF PAIN

Washington State Department of Health

Medical Quality Assurance Commission

Adopted 1998

A. Introduction

There are widespread concerns among patients throughout the state about access to appropriate medical treatment, including opioid therapy, for addressing chronic intractable pain. Similarly, providers express apprehensions about challenges by state disciplinary authorities when prescribing opioid analgesics for indicated medical treatment when serving the legitimate medical needs of pain patients. The undertreatment of chronic pain due to concerns about addiction and drug diversion affect the public health, safety, and welfare. There is a need for guidance which would: a) encourage appropriate treatment for pain management; b) reduce providers' fear of injudicious discipline; and c) protect the public from inappropriate prescribing practices and diversion.

B. Purpose statement

The Secretary of the Department of Health recommends the uniform adoption, by appropriate state regulatory authorities, of the following guidelines when managing pain. It is not the intent of these guidelines to define complete standards of acceptable medical care in the treatment of pain patients. These guidelines are not intended to direct clinical practice parameters. It is the intent that providers will have confidence that these guidelines are the standard by which opioid usage is evaluated.

C. Policy statement

Under generally accepted standards of medical practice, opioids may be prescribed for the treatment of acute or chronic pain including chronic pain associated with cancer and other noncancer pain conditions. Prescribing opioids requires special consideration. It is the position of the Department of Health that opioids may be prescribed, dispensed, or administered when there is an indicated medical need without fear of injudicious discipline.

D. Guidelines for opioid usage

1) Acute pain

Opioids are useful for patients with acute pain such as surgery, burn, or trauma. The goal of such treatment is to provide adequate and timely pain management to the patient. Side effects of opioids that are difficult to treat may occur and must be balanced against the benefits of pain relief. The provider should, for any patient who has a history of alcoholism or other drug addictions, carefully monitor medications and when available seek appropriate consultation.

2) Chronic Pain Associated with Cancer

Chronic pain associated with cancer may often be successfully managed with opioids. If use of opioids is the primary analgesic strategy, adequate doses should be given frequently enough to keep the patient continuously comfortable. Addiction is rare in patients with cancer pain; tolerance and physical dependency are often unavoidable and should not interfere with opioid prescribing. Not all pain in patients with cancer is responsive to opioids; alternative strategies for managing the pain should also be made available.

3) Other Chronic Pain Conditions

Opioid analgesics can be useful in the treatment of patients with intractable noncancer pain especially, where efforts to remove the cause of pain or to treat it with other modalities have failed or were not fully successful. The pain of such patients may have a number of different etiologies and may require several modalities. In addition, the extent to which pain is associated with psychological, physical, and social impairment varies greatly. Therefore, the selection for a trial of opioid therapy should be based on a careful assessment of the pain as well as the impairment experienced by the patient. Continuation of opioid therapy should be based on the provider's evaluation of the results of treatment, including the degree of pain relief, changes in psychological, physical, and social functioning, and appropriate utilization of health services. Providers are encouraged to obtain consultation from providers who are knowledgeable in pain management, particularly when managing patients with a history of alcohol abuse or previous chronic opioid use.

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E. Definitions

1. **Addiction** – A disease process involving use of psychoactive substances wherein there is loss of control, compulsive use, and continued use despite adverse social, physical, psychological, or spiritual consequences.
2. **Physical dependence** – A physiologic state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence is not necessarily associated with full blown addiction, and condition does not always equate with addiction.
3. **Psychological dependence** – A subjective sense of need for a specific substance, either for its positive effects or to avoid negative effects associated with its abstinence.
4. **Tolerance** – State in which an increased dosage of a psychoactive substance is needed to produce a desired effect.
5. **Withdrawal syndrome** – The onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a psychoactive substance.
6. **Acute pain** – An essential biologic signal of the potential for or the extent of injury. It is usually short-lived and is associated with hyperactivity of the sympathetic nervous system; e.g. tachycardia, increased respiratory rate and blood pressure, diaphoresis, and papillary dilation. The concurrent affect is anxiety.
7. **Chronic pain** – Pain persistent beyond expected healing time and often cannot be ascribed to a specific injury. Chronic pain may not have a well-defined onset and by definition does not respond to treatment directed at its causes.
8. **Intractable pain in a noncancer patient** – Pain in which the cause cannot be removed or otherwise treated and no relief or cure has been found after reasonable efforts.

F. Guidelines for assessment and documentation in noncancer pain

Alternative strategies for managing pain must be explored. If alternative strategies for managing the pain are unsuccessful, long term opioid therapy can be added. The goal is not merely to treat the symptoms of pain, but to devise pain management strategies which deal effectively with all aspects of the patient's pain syndrome, including psychological, physical,

social, and work-related factors.

Documentation in the patient's medical record should include:

1. **History and medical examination** – A complete physical examination and comprehensive medical history should be part of the active treatment record including, but not limited to, a review of past pain treatment outcomes and any history of addiction risks to establish a diagnosis and treatment plan.
2. **Diagnosis and medical indication** – A working diagnosis must be delineated, which includes the presence of a recognized medical indication for the use of any treatment or medication.
3. **Written treatment plan with recorded measurable objectives** – The plan should have clearly stated, measurable objectives, indication of further planned diagnostic evaluation, and alternative treatments.
4. **Informed consent** – Discussions of risks and benefits should be noted in some format in the patient's record.
5. **Periodic reviews and modifications indicated** – At these periodic reviews, the provider should reassess the treatment plan, the patient's clinical course, and outcome goals with particular attention paid to disease progression, side effect and emergence of new conditions.
6. **Consultation** – The treating provider should be knowledgeable and competent in referring patients to the appropriate specialist if needed and noting in the patient's record the treating provider's interpretation of the consultation reports. Additionally, a new patient with evidence of at-risk patterns of opioid usage should be evaluated by a knowledgeable specialist.
7. **Records** – The provider should keep accurate and complete records documenting the dates and clinical findings for all evaluations, consultations, treatments, medications and patient instructions.
8. **Assessment and monitoring** – Some patients with chronic pain not associated with cancer may be at risk of developing increasing opioid consumption without objective improvement in functional status. Subjective reports by the patient should be supported by objective observations. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, patient consumption of

Medical Treatment Guidelines

health care resources, positive answers to specific questions about the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient as observed by the physician.

Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a disease with behavior characterized by psychological dependence and aberrant drug related behaviors. Addicts compulsively use drugs for non-medical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts merely because they are being treated with opioids.

The physician is responsible for monitoring the dosage of the opioid. Monitoring includes ongoing assessment of patient compliance with drug prescriptions and related treatment plans. Communication between health care providers is essential. The patient should receive long term analgesic medications from one physician and where possible one pharmacy. All providers should be particularly cautious with patients with a history of alcoholism or other drug addiction when prescribing long term opioids. Consults with addiction specialists are recommended.

G. Patient Responsibilities

1. It is the patient's responsibility to candidly provide the treatment provider with a complete and accurate treatment history, including past medical records, past pain treatment and alcohol and other drug addiction history.
2. The patient should participate as fully as possible in all treatment decisions.
3. The patient and family members, if available, should inform the prescriber of all drug side effects and concerns regarding prescription drugs.
4. The patient should not use other psychoactive agents, including alcohol, naturopathic products or over-the-counter drugs without agreement to the prescriber.
5. The patient should use the same name when receiving medical care to assure completeness of the medical record.
6. The patient should demand respect and expect to be believed.
7. The patient should keep an open mind and be willing to work with the treatment provider, including:
 - a. negotiate with the provider to arrive at an acceptable plan of treatment;
 - b. be open in trying alternative treatment strategies; and
 - c. follow the treatment provider's instructions precisely.
8. The patient should, where possible, get all central nervous system medications from one provider. If this is not possible, the patient should inform each provider of all medications he/she is receiving.
9. The patient should, where possible, have all prescriptions filled at a single pharmacy.
10. The patient should not hoard, share, or sell medications.
11. The patient should be aware that providers may, by law, share information with other providers about the patient's care.

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APPENDIX 2

HOW WERE THESE GUIDELINES DEVELOPED?

These guidelines were developed by the Washington State Department of Labor and Industries (L&I) in collaboration with the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee. The WSMA is charged by the Washington Administrative Code with the responsibility and authority to advise L&I on issues relating to medical care of injured workers.

Beginning in 1998 numerous meetings of the Treatment Guidelines Subcommittee were devoted to discussion of medical, legal, adjudicative and other aspects of chronic pain management. The subcommittee consisted of physicians representing a variety of specialties, including anesthesiology, internal medicine, neurology, occupational medicine, orthopedic surgery, physical medicine and rehabilitation, and plastic surgery, among others. The subcommittee included one doctor who had participated in the creation of the Department of Health "Guidelines for Management of Pain."

The subcommittee carefully reviewed the medical literature on the topic of opioids and their use for chronic noncancer pain. The subcommittee refined a series of drafts, then used a consensus process to arrive at a draft for wider distribution and comment.

The subcommittee solicited and received comments from dozens of authorities from many parts of the United States. The authorities represented a spectrum of disciplines, specialties and perspectives, including non-physicians such as representatives of patient advocacy organizations.

After further discussion and incorporation of changes based on stakeholder input, the subcommittee presented a final draft to the WSMA and recommended that the WSMA approve the guidelines. The WSMA approved the guidelines in April 1999. Additional comments were received, and the WSMA approved a number of enhancements to the guidelines. These guidelines are intended to be reviewed and amended on a regular basis depending on emerging scientific data and on changing community standards.

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APPENDIX 3

SAMPLE OPIOID TREATMENT AGREEMENT

Patient Name: _____

Date: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

To the doctor: Keep signed originals in your file; give a photocopy to the patient. Renew at least every 6 months.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____.

1. I understand that I have the following responsibilities:
 - a. I will take medications only at the dose and frequency prescribed.
 - b. I will not increase or change medications without the approval of this doctor.
 - c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
 - d. I will not request opioids or any other pain medicine from physicians other than from this doctor. This doctor will approve or prescribe all other mind and mood altering drugs.
 - e. I will inform this doctor of all other medications that I am taking.
 - f. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement.
 - g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
 - h. I agree to participate in psychiatric or psychological assessments, if necessary.
 - i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor

may ask me to follow through with a program to address this issue. Such programs may include the following:

- 12-step program and securing a sponsor
- Individual counseling
- Inpatient or outpatient treatment
- Other: _____

2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:
 - a. I do not show any improvement in pain from opioids or my physical activity has not improved.
 - b. My behavior is inconsistent with the responsibilities outlined in #1 above.
 - c. I give, sell or misuse the opioid medications.
 - d. I develop rapid tolerance or loss of improvement from the treatment.
 - e. I obtain opioids from other than this doctor.
 - f. I refuse to cooperate when asked to get a drug screen.
 - g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
 - h. If I am unable to keep follow-up appointments.

Patient Signature

Date

Physician Signature

Date

Medical Treatment Guidelines

SAMPLE OPIOID TREATMENT AGREEMENT (*continued*)

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Vomiting
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation of depression
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.

RISKS:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
 - Runny nose
 - Diarrhea
 - Sweating
 - Rapid heart rate
 - Difficulty sleeping for several days
 - Abdominal cramping
 - 'Goose bumps'
 - Nervousness
- Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
- Tolerance. This means you may need more and more drug to get the same effect.
- Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician.

PAYMENT OF MEDICATIONS:

State law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. You and your doctor should discuss other sources of payment for opioids when L&I can no longer pay.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

Patient Signature

Date

Physician Signature

Date



FUNCTIONAL PROGRESS FORM

Please return this form to L&I at the address above for state fund claims
OR mail it directly to the self-insured company for self-insured claims.

Though voluntary, the attending physician is strongly encouraged to use this form to track the patient's progress over time.

How can I help my patient regain function and return to work?

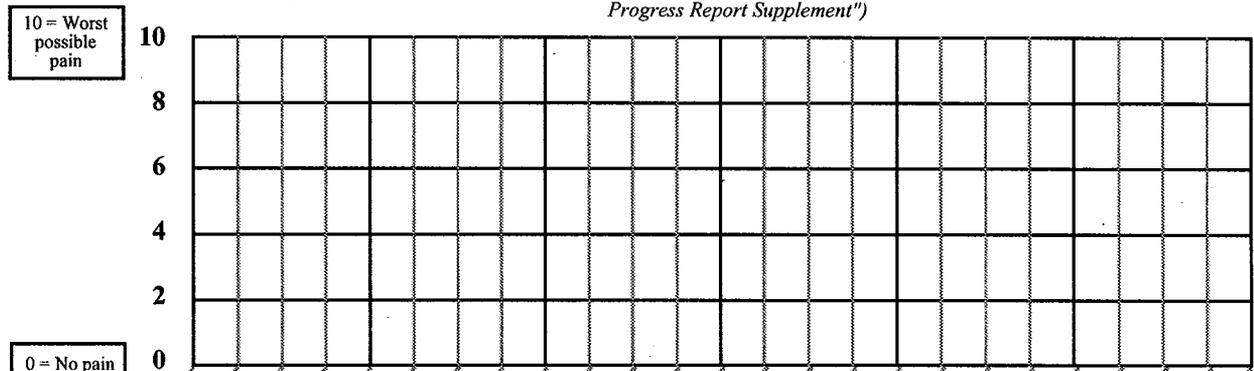
1. At each office visit, use this form to chart your patient's functional progress.
2. Speak with the employer (or potential employers) to explore light-duty and/or modified work. Remember \$5,000 may be available for job modifications.
3. Ask for help from the claim manager and/or nurse consultant (1-800-848-0811).
4. **When your patient's progress has reached a plateau:** please consider a consult. Or, if you feel the patient has reached maximum medical improvement, please consider doing an impairment rating or ask the department to obtain an independent medical examination.
5. For more information, see pages 9 - 14 of the Attending Doctor's Handbook (available at 1-800-848-0811).

Patient name		Date of injury	L&I Claim number
Employer Contact and phone:		Vocational Counselor and phone:	
Claim Manager and phone:		Nurse Consultant at L&I and phone:	

For what diagnosis(es) are you using opioids?

Start date of treatment
 / /

Graph 1: Pain Summary (When treating with opioids, this estimate is the answer to question # 1 in "Opioid Progress Report Supplement")

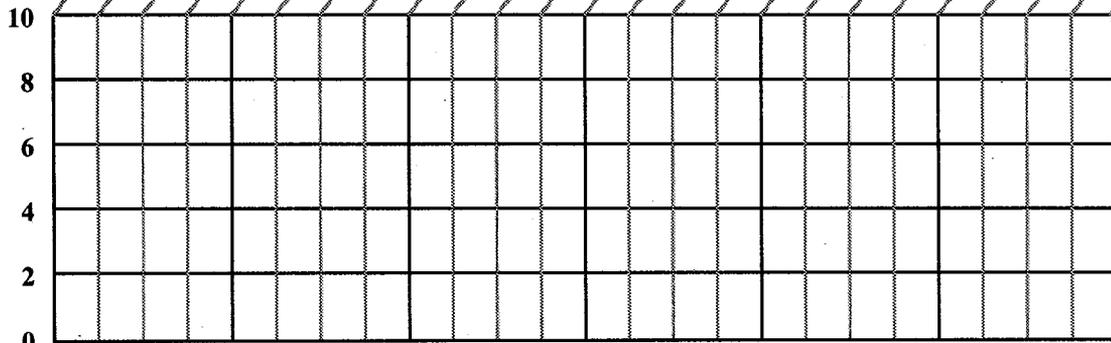


PLACE DATE OF OFFICE VISIT ON SLANTED LINES

10 = Level of function prior to injury

5 = Partially recovered function since injury

0 = Severe impact on function at home or work.



Graph 2: Functional Progress Summary (When treating with opioids, this estimate is the answer to question #6b in "Opioid Progress Report Supplement.")

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Summary of policy changes

Until recently, the Washington Administrative Code (WACs) prohibited payment for opioids prescribed to injured workers for the treatment of chronic pain. Those rules were changed effective January 20, 2000. The department or self-insurer can now pay for opioids to treat chronic, noncancer pain as long as the worker:

- Has substantial reduction in pain and continuing substantial improvement in function, and
- Has not reached maximum medical improvement.

Summary of authorization and documentation requirements

In accordance with these new rules on the payment for opioids to treat chronic, noncancer pain, the treating physician is required to submit two new reports and a treatment agreement. These reports are needed for the department or self-insurer to authorize payment and to monitor your patient's progress. The *Opioid Progress Report Supplement* is required in addition to regular 60-day progress reports. Please review the table below to see, at a glance, more information about this required documentation. Copies of the *Opioid Progress Report Supplement* and *Functional Progress Form* can be found on pages 88 and 89.

When are reports needed?	Type of Report	Frequency of Report	Billing code	For details see:
When initiating treatment with opioids for chronic, noncancer pain	Initial report documenting the need for opioid treatment* (narrative)	All three of these reports are needed at the initiation of treatment for chronic, noncancer pain	1064M	WAC 296-20-03020
	Opioid Progress Report Supplement -for baseline measurements of pain/function (department form) <i>F245-359-000</i>		1057M	WAC 296-20-03021 WAC 296-20-03022 Attached form (page 88)
	Treatment agreement			WAC 296-20-03020 <i>Sample treatment agreement:</i> Pages 86-87 of this Provider Bulletin or on the Internet at http://www.lni.wa.gov/Claims/Providers/Treatment/Presc/Policy/Opioid/default.asp
With ongoing treatment	Opioid Progress Report Supplement (department form) <i>F245-359-000</i>	At least every 60 days	1057M	WAC 296-20-03021 WAC 296-20-03022 Attached form (page 88)
	Functional Progress Form (department form) <i>F245-363-000</i>	Use of this form is voluntary but is encouraged after each visit to help track improvement		Attached form (page 89)
	Treatment agreement	Every six months		WAC 296-20-03020 <i>Sample treatment agreement:</i> Pages 86-87 of this Provider Bulletin or on the Internet at http://www.lni.wa.gov/Claims/Providers/Treatment/Presc/Policy/Opioid/default.asp

*No later than thirty days after the attending physician begins treating the worker with opioids for chronic, noncancer pain, the attending physician must submit a written report to the department or self-

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insurer in order for the department or self-insurer to pay for such treatment. See WAC 296-20-03020 for details.

What are the billing rules?

Physicians should bill the appropriate E&M codes for the evaluation and treatment of injured workers who may require opioids for the treatment of chronic, noncancer pain. Additionally, physicians may bill appropriate local codes, described in the next section, for preparation and submission of the initial documentation which establishes the necessity for treating the worker with opioids (See WAC 296-20-03020) and for the *Opioid Progress Report Supplement* (See WAC 296-20-03021).

What are the billing codes?

Use local code 1064M for the preparation and submission of the initial narrative report establishing the necessity of opioid treatment.

Use local code 1057M for the preparation and submission of the *Opioid Progress Report Supplement*.

Where can I obtain the new opioid forms?

All department forms can be obtained from the warehouse at:

Warehouse
Department of Labor & Industries
PO Box 44843
Olympia, WA 98504-4843

Use form # F245-359-000 to order the required *Opioid Progress Report Supplement*.

Use form # F245-363-000 to order the optional *Functional Progress Form*.

Both of these forms can also be found on the department's Internet home page via the "Forms" link at <http://www.lni.wa.gov/FormPublications/>

Please note the following regarding coverage for prescriptions of injectable/parenteral opioids.

In general, prescriptions for injectable opioids are not covered. See WAC 296-20-03014 for exceptions. In addition, all other nonoral routes of administration of scheduled drugs that result in systemic availability of the drug equivalent to injectable routes will also not be covered.

For example: Use of the transdermal fentanyl system (Duragesic®) for chronic, noncancer pain will not be routinely covered. We have reviewed the literature and safety profile of this product. While the drug is absorbed relatively slowly, it reaches peak levels equivalent to intravenous use and is metabolized and excreted slowly. Therefore, because the pharmacokinetics of transdermal fentanyl demonstrates systemic availability that is equivalent to injectable routes, this product will not be routinely covered.

In addition, the FDA-approved product labeling states in part that Duragesic® is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain *that cannot be managed by lesser means*.

Therefore, on an exception basis only, the department will pay for the transdermal fentanyl system (Duragesic®) when the patient requires continuous opioid analgesia for pain that cannot be managed by lesser means AND, either

1. Other long-acting opioids cannot be tolerated, or
2. Medical contraindications preclude the use of oral opioids (e.g., the patient can't swallow pills, the patient has dementia and might not take the right amount of pills at the right time.)

Note: This does not apply to the use of opioids in the treatment of cancer pain. See WAC 296-20-03014.

Medical Treatment Guidelines

Changes to the Washington Administrative Code (WAC)

Until recently, the Washington Administrative Code (WACs) prohibited payment for opioids prescribed to injured workers for the treatment of chronic pain. Those rules were changed effective January 20, 2000. The revised WACs pertaining to opioids are presented below. (Please see Provider Bulletin 00-01 for a complete listing of the new drug and medication rules.)

WAC 296-20-03014

Which drugs have specific limitations?

- (1) **Injectables.** Prescriptions for injectable opioids or other analgesics, sedatives, antihistamines, tranquilizers, psychotropics, vitamins, minerals, food supplements, and hormones are not covered. Exceptions: The department or self-insurer covers injectable medications under the following circumstances.
 - (a) Indicated injectable drugs for the following:
 - Inpatients; or
 - During emergency treatment of a life-threatening condition/injury; or
 - During outpatient treatment of severe soft tissue injuries, burn or fractures when needed for dressing or cast changes; or
 - During the perioperative period and the postoperative period, not to exceed forty-eight hours from the time of discharge.
 - (b) Prescriptions of injectable insulin, heparin, anti-migraine medications, or impotency treatment, when proper and necessary.
- (2) **Noninjectable scheduled drugs administered by other than the oral route.** Nonoral routes of administration of scheduled drugs that result in systemic availability of the drug equivalent to injectable routes will also not be covered.
- (3) **Sedative-hypnotics.** During the chronic stage of an industrial injury or occupational disease, payment for scheduled sedatives and hypnotics will not be authorized.
- (4) **Benzodiazepines.** Payment for prescriptions for benzodiazepines are limited to the following types of patients:
 - Hospitalized patients;
 - Claimants with an accepted psychiatric disorder for which benzodiazepines are indicated;
 - Claimants with an unrelated psychiatric disorder that is retarding recovery but which the department or self-insurer has temporarily authorized treatment (see WAC 296-20-055) and for which benzodiazepines are indicated; and
 - Other outpatients for not more than thirty days for the life of the claim.
- (5) **Cancer.** When cancer or any other end-stage disease is an accepted condition, the department or self-insurer may authorize payment for any indicated scheduled drug and by any indicated route of administration.
- (6) **Spinal cord injuries.** When a spinal cord injury is an accepted condition, the department or self-insurer may authorize payment for anti-spasticity medication by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

Note: See the department formulary for specific limitations and prior authorization requirements of other drugs.

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WAC 296-20-03019 Under what conditions will the department or self-insurer pay for oral opioid treatment for chronic, noncancer pain?

Chronic, noncancer pain may develop after an acute injury episode. It is defined as pain that typically persists beyond two to four months following the injury.

The department or self-insurer may pay for oral opioids for the treatment of chronic, noncancer pain caused by an accepted condition when that treatment is proper and necessary. See WAC 296-20-01002 for the definition of “proper and necessary” health care services.

WAC 296-20-03020 What are the authorization requirements for treatment of chronic, noncancer pain with opioids?

No later than thirty days after the attending physician begins treating the worker with opioids for chronic, noncancer pain, the attending physician must submit a written report to the department or self-insurer in order for the department or self-insurer to pay for such treatment. The written report must include the following:

- A treatment plan with time-limited goals;
- A consideration of relevant prior medical history;
- A summary of conservative care rendered to the worker that focused on reactivation and return to work.
- A statement on why prior or alternative conservative measures may have failed or are not appropriate as sole treatment;
- A summary of any consultations that have been obtained, particularly those that have addressed factors that may be barriers to recovery;
- A statement that the attending physician has conducted appropriate screening for factors that may significantly increase the risk of abuse of adverse outcomes (e.g., a history of alcohol or other substance abuse); and
- An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement must be renewed every six months. The treatment agreement must outline the risks and benefits of opioids use, the conditions under which opioids will be prescribed the physician’s need to document overall improvement in pain and function, and the worker’s responsibilities.

WAC 296-20-03021 What documentation is required to be submitted for continued coverage of opioids to treat chronic, noncancer pain?

In addition to the general documentation required by the department or self-insurer, the attending physician must submit the following information at least every sixty days when treating with opioids:

- Documentation of drug screenings, consultations, and all other treatment trials;
- Documentation of outcomes and responses, including pain intensity and functional levels; and
- Any modifications to the treatment plan.

The physician must use a form developed by the department, or a substantially equivalent form, to document the patient’s improvement in pain intensity and functional levels. This form may be included as part of a sixty-day report.

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WAC 296-20-03022 How long will the department or self-insurer continue to pay for opioids to treat chronic, noncancer pain?

The department or self-insurer will continue to pay for treatment with opioids so long as the physician documents:

- Substantial reduction of the patient's pain intensity; and
- Continuing substantial improvement in the patient's function.

Once the worker's condition has reached maximum medical improvement, further treatment with opioids is not payable. Opioid treatment for chronic, noncancer pain past the first three months of such treatment without documentation of substantial improvement is presumed to be not proper and necessary.

WAC 296-20-03023 When may the department or self-insurer deny payment of opioid medications used to treat chronic, noncancer pain?

Payment for opioid medications may be denied in any of the following circumstances:

- Absent or inadequate documentation;
- Noncompliance with the treatment plan;
- Pain and functional status have not substantially improved after three months of opioid treatment; or
- Evidence of misuse or abuse of the opioid medication or other drugs, or noncompliance with the attending physician's request for a drug screen.

WAC 296-20-03024 Will the department or self-insurer pay for nonopioid medications for the treatment of chronic, noncancer pain?

The department or self-insurer may pay for nonopioid medication for the treatment of chronic, noncancer pain when it is proper and necessary.

For example, some drugs such as anti-convulsants, anti-depressants, and others have been demonstrated to be useful in the treatment of chronic pain and may be approved when proper and necessary.

Guideline for the use of Neurontin® in the Management of Neuropathic Pain

Purpose of the Guideline

The purpose of this guideline is to provide assistance to treating physicians in the use of Neurontin® in the management of neuropathic pain. Neuropathic pain may be defined as pain initiated or caused by a primary lesion or dysfunction in the nervous system, and is characterized by spontaneous pain described as lancinating, paroxysmal, burning, constant, cramping; and evoked pain of dysesthesia, allodynia, hyperalgia, or hyperpathia.

Treatment Guideline for the use of Neurontin® for Neuropathic Pain

Since gabapentin is currently only available under the trade name Neurontin®, the trade name will be used in this guideline. Neurontin® has been approved for use in the treatment of post-herpetic neuralgia and there is scientific research that indicates it may be effective in the treatment of other conditions that result in neuropathic pain. There is no scientific evidence that Neurontin® is effective in treating acute pain, somatic pain from sprains or strains, or myofascial pain. In this guideline, chronic pain has been classified into three categories with recommendations for use of Neurontin® for each category:

Category 1

Neurontin® is most likely to be effective when it is prescribed for the following neuropathic pain conditions:

- Peripheral nerve injury
- Peripheral polyneuropathy
- Cauda equina syndrome
- Spinal cord injury
- Complex Regional Pain Syndrome Type II (CRPS Type II)
- HIV and cancer related neuropathies
- Radiculopathy, chronic, not acute
- Other conditions with objective finding of nerve injury and a clearly documented history of neuropathic symptoms

Category 2

Neurontin® is less likely to be effective when it is prescribed for questionable neuropathic pain conditions with no objective findings of nerve injury, such as CRPS Type I. Accordingly, prescriptions for Neurontin® for questionable neuropathic pain conditions with no objective findings of nerve injury should be written only after prior consultation and recommendation from a physician specializing in pain therapies, rehabilitation and physical medicine, or neurology.

Reference: Provider Bulletin 02-11; Date Introduced: December 2002

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Category 3

There is no credible scientific evidence that Neurontin® is effective in relieving pain associated with the following non-neuropathic pain conditions:

- Acute musculoskeletal pain
- Primary somatic pain from chronic musculoskeletal strain/sprain
- Low back pain without radiculopathy
- Tendinitis
- Repetitive strain without evidence of entrapment neuropathy

Payment for Neurontin® may be denied by the claim manager when prescribed for conditions listed in Category 3; or for conditions listed in Category 2 without a prior consultation and recommendation from a physician specializing in pain therapies, rehabilitation and physical medicine, or neurology. Please contact the unit Occupational Nurse Consultant if there are any questions.

Recommended Dosage (Neurontin® Package Insert. May 2002)²

Individual drug tolerance and pain-relief dosage may vary considerably, however, Neurontin® effectiveness in reducing neuropathic pain should be seen by 4 to 6 weeks. The following is a recommended dosing plan for Neurontin® in the management of neuropathic pain.

Neurontin® therapy may be initiated as a 100 to 300 mg dose at bedtime and increased to 600 to 900 mg/day over 3 days (given in three divided doses). If this is tolerated, the dose may be titrated up every 2 to 3 days as tolerated until a daily dose of 1800 mg/day (given in three divided doses) is reached. If significant pain relief is achieved at a lower dose and no increased improvement is noted with further dose increases, the lower dose should be maintained.

If no improvement is seen with Neurontin® at 1800 mg/day, the dose may be increased up to 2400 mg/day. If no improvement is seen at 2400 mg/day, consider tapering Neurontin® to see if pain level increases. If pain level remains the same, discontinue Neurontin®. As no additional benefit is seen with doses greater than 1800 mg/day and the absorption of Neurontin® follows saturation biokinetics (an increasing dose of Neurontin® results in a decreasing percentage of Neurontin® absorption), further increases in doses are not recommended.

The most common side effects associated with the use of Neurontin® in adults are dizziness, somnolence, and peripheral edema. Accordingly, patients should be advised not to drive a car or operate other complex machinery until they have gauged whether or not Neurontin® affects their mental and/or motor performance.

In addition, patients who require concomitant treatment with morphine may experience increases in gabapentin concentrations and should be observed for signs of CNS depression and the dose of Neurontin® or morphine should be reduced appropriately. Please refer to Neurontin® Package Insert for complete prescribing instructions.

² Neurontin® Package Insert. May 2002

Guideline on Facet Neurotomy

Documentation of pain relief following diagnostic blocks

No pain medication should be taken for four hours prior to each diagnostic medial nerve block or facet joint block. No IV sedation should be administered before or during a diagnostic block except in an extreme case of anxiety. Prior to the block, pain should be reproducible with positioning of the patient, to at least a “4” on a 0-10 scale.

After each diagnostic block the injured worker must document the level of pain relief obtained using the *Neurotomy Workup Pain Relief Report Form* found in this guideline. The form may be copied as needed. The injured worker is to engage in the activities that previously produced pain and document the level of pain relief obtained every 15 minutes for a minimum of six hours following each block, or until their usual level of pain returns. The completed form is to be returned to the physician at the next scheduled office visit. Place a copy of the completed Pain Relief Form in the medical record, send a copy to the department, and another copy to Qualis if a facet neurotomy is requested.

Reactivation and maximum medical improvement following a facet neurotomy

A formal plan for reactivation must be developed, and agreed upon by the injured worker, prior to a facet neurotomy. If indicated, vocational assessment and/or plan development should be considered prior to the procedure. Progressive reactivation, as appropriate based on the injured worker’s condition, may include up to four weeks of outpatient physical therapy or occupational therapy, or work hardening. At the conclusion of the post procedure reactivation the injured worker should be at maximum medical improvement.

Will the department pay for an additional facet neurotomy?

The department will pay for **only one** facet neurotomy on the same side and at the same level for an injured worker. The department will reimburse for facet neurotomies at not more than 2 joint levels unilaterally or bilaterally on the same day. Diagnostic blocks will be reimbursed at not more than 2 joint levels bilaterally or 3 joint levels unilaterally. The department will not pay for the following procedures:

- Dorsal rhizotomy
- Thoracic neurotomy
- SI joint neurotomy
- Ganglionectomy, or
- Transaction or avulsion of other extradural spinal nerves.

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Criteria for Cervical or Lumbar Facet Neurotomy

Inclusion Criteria

CONSERVATIVE CARE	Clinical Findings	
CARE	SUBJECTIVE/ OBJECTIVE	DIAGNOSTIC TESTS
<p>Failure of 6 months of non-invasive therapy such as physical therapy, medications, or manual therapy (mobilization/manipulation)</p>	<p style="text-align: center;">AND</p> <p>Non-radicular neck or back pain. AND Segmental pain or tenderness at the level of the potentially involved facet and not more than 3 joint levels unilaterally or 2 joint levels bilaterally. AND Neurologically intact for the region involved.</p> <p style="text-align: center;">OR</p> <p>If neurologic deficit is present, it should be addressed in the treatment plan.</p>	<p style="text-align: center;">AND</p> <p>Diagnostic testing as required to rule out any correctable structural lesion to include CT or MRI. Diagnostic blocks should not involve more than 3 joint levels unilaterally or 2 joint levels bilaterally. AND Minimum of at least 2 differential local anesthetic blocks. One block must be of the medial branch of the dorsal ramus innervating the targeted facet joints; the other block may be an intraarticular facet joint block. AND Differential blocks may be either 0.5 ml total volume of a short acting local anesthetic (2% to 4% lidocaine); or 0.5 ml total volume of a long acting local anesthetic (0.5% to 0.75% bupivacaine). AND Steroid may be used with a local anesthetic for the intraarticular block but total volume of both local and steroid should not exceed 0.5 ml for cervical injection and 0.75 ml for lumbar injection. AND Minimum of 80% pain relief following each block while performing activities that previously provoked pain. Documentation of pain relief should be a patient-generated report in real-time, every 15 minutes for the first six hours following the block. AND Duration of pain relief should be consistent with the expected duration of the local anesthetic injected (at least 1 hour for short acting and at least 2 hours for long acting local anesthetic). AND/OR Placebo controlled blocks may be used to resolve any ambiguity of results of local anesthetic blocks.</p>

Exclusion Criteria that would require UR physician review

- Radiculopathy
- Anticipated cervical, thoracic, or lumbar surgery
- Anticipated surgery for any other condition
- Previous fusion at the targeted level

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- Diagnosed with a psychiatric condition likely to interfere with diagnostic accuracy of the workup protocol or with recovery following the anticipated procedure
- Multiple, focal, chronic pain syndromes (i.e., CRPS, fibromyalgia, chronic fatigue syndrome)

FACET NEUROTOMY WORKUP PAIN RELIEF REPORT FORM

Directions: This form is to be completed by the patient, or someone recording the patient's responses, in "real time" following the administration of a facet block. **Pain relief level should be recorded while doing activities that previously caused pain.** Please fill in the date and time of your block was performed, then circle the time the block was completed on the time chart. Every 15 minutes put a check mark in the time chart box that most accurately describes the degree of your pain relief. Continue to put check marks in the appropriate time chart box **every fifteen minutes for a full 6 hours** following the block. This form needs to be returned to the physician who performed your block at your next scheduled visit, since it will become part of your medical record.

Name: _____

Date of block: _____

Time of block _____

My pain is:

Time (Circle the time of the block)	100% Totally gone	80% Pretty much gone	50% Half way gone	20% Barely gone	0% Usual level, no relief	Time	100% Totally gone	80% Pretty much gone	50% Half way gone	20% Barely gone	0% Usual level, no relief
8:00 am						4:00 pm					
8:15						4:15					
8:30						4:30					
8:45						4:45					
9:00 am						5:00 pm					
9:15						5:15					
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2:45						10:45					
3:00 pm						11:00pm					
3:15						11:15					
3:30						11:30					
3:45						11:45					

Review Criteria for Inpatient Chronic Pain Clinic Treatment

Review criteria for approval at the nurse reviewer level:

Multidisciplinary Chronic Pain Clinic treatment has been authorized by the claim manager;

AND

Impairment in functional status and ability to perform activities of daily living with at least 5 hours of inactivity per day due to pain;

AND

- Failed improvement in functional status in outpatient PT;
- AND
- Able to actively participate in comprehensive rehabilitation (PT, OT) including 3 or more hours per day, 5 days per week;

OR

Requires nursing service 24 hours per day;

AND

- Complex co-morbid condition such as, but not limited to, asthma, malignant hypertension, heart disease, or psychologically fragile;

OR

- Failed outpatient withdrawal from controlled substances;

OR

- History of seizures with prior attempts at medication withdrawal.

Date Introduced: January 2005